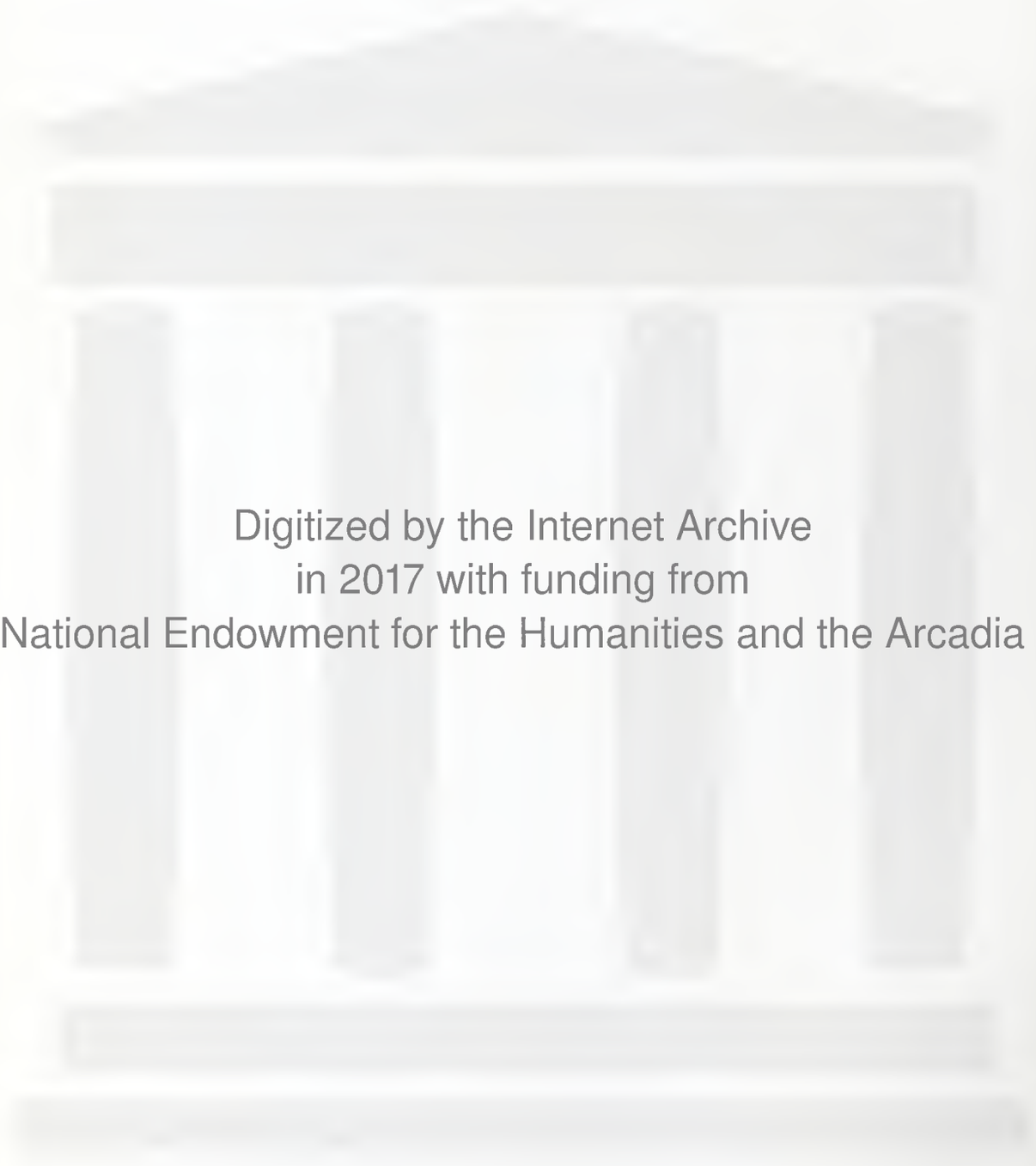


ALASKA MEDICINE

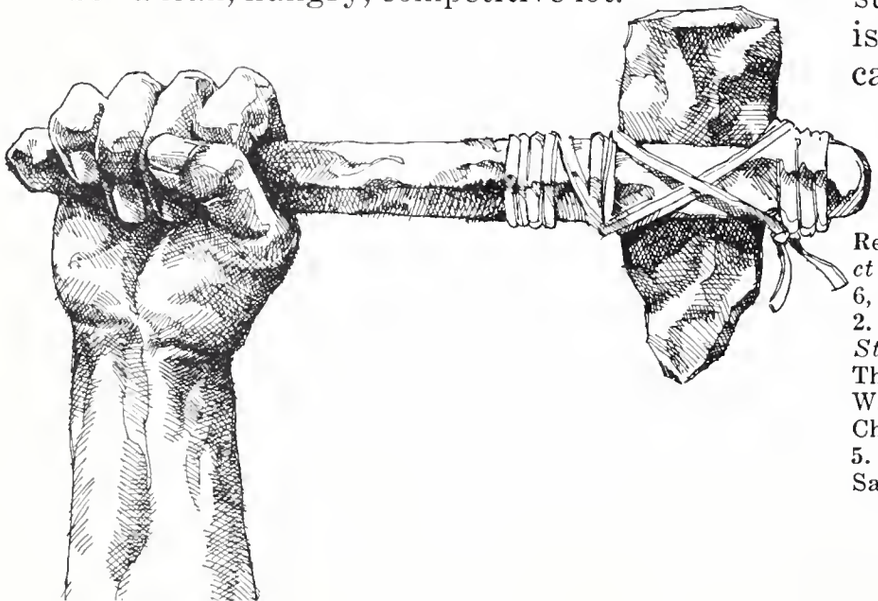
Volume 14, Number 1, January 1972

IF MORE MEN CRIED

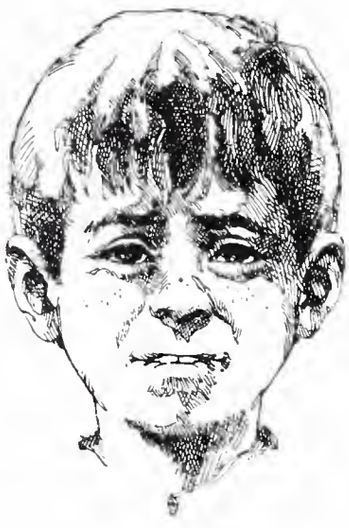
At least seventy-five out of one hundred adults with duodenal ulcers are men.[1] Why? It may be significant that duodenal ulcer patients tend to crave recognition and are "especially vulnerable to threats to their manly assertive independence."[2]

Hypersecretion—an atavistic response. Stewart Wolf, who, with Harold G. Wolff, studied the personalities of duodenal ulcer patients, wonders if masculine competitiveness is related to "an atavistic urge to devour an adversary." It is striking, he reports, that an accentuation of gastric acid secretion and motility can be "induced in ulcer patients by discussions that arouse feelings of inadequacy, frustration and resentment."[2]

By chance? A lean, hungry lot. Was the link between emotions and gastric hyperacidity acquired through mutation to serve a purpose? During man's jungle period of evolution, the investigator points out, a male dealt with a foe by killing and devouring it. "It may be more than coincidence," he concludes, that peptic ulcer patients appear to be "a lean, hungry, competitive lot."[3]



Big boys don't cry. If more men cried, maybe fewer would wind up with duodenal ulcers. But men will be men—the sum total of their genes and what they are taught. Schottstaedt observes that when a mother admonishes her son who has hurt himself that big boys don't cry, she is teaching him stoicism.[4] Crying is the negation of everything society thinks of as manly. A boy starts defending his manhood at an early age.



Take away stress, you can take away symptoms. There is no question that stress plays a role in the etiology of duodenal ulcer. Alvarez[5] observes that many a man with an ulcer loses his symptoms the day he shuts up the office and starts out on a vacation. The problem is, the type of man likely to have an ulcer is the type least likely to take long vacations or take it easy at work.

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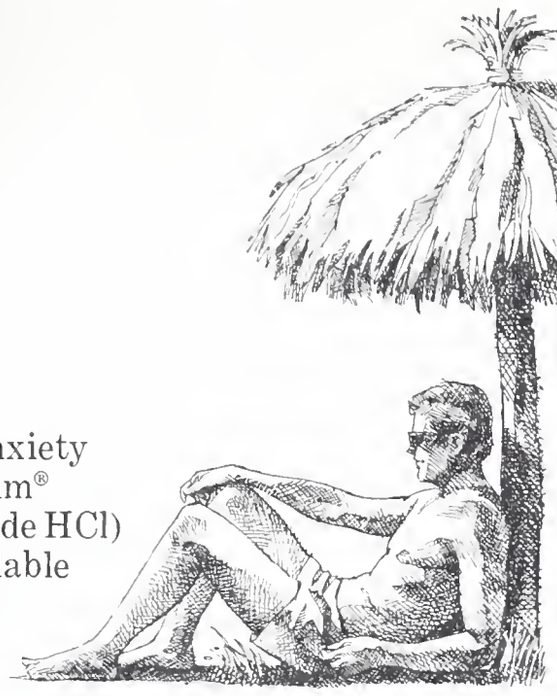
References: 1. Silen, W.: "Peptic Ulcer," in Wintrobe, M. M., *et al.* (eds.): *Harrison's Principles of Internal Medicine*, ed. 6, New York, McGraw-Hill Book Company, 1970, p. 1444. 2. Wolf, S., and Goodell, H. (eds.): *Harold G. Wolff's Stress and Disease*, ed. 2, Springfield, Ill., Charles C Thomas, 1968, pp. 68-69. 3. *Ibid.*, p. 257. 4. Schottstaedt, W. W.: *Psychophysiologic Approach in Medical Practice*, Chicago, Ill., The Year Book Publishers, Inc., 1960, p. 163. 5. Alvarez, W. C.: *The Neuroses*, Philadelphia, Pa., W. B. Saunders Company, 1951, p. 384.



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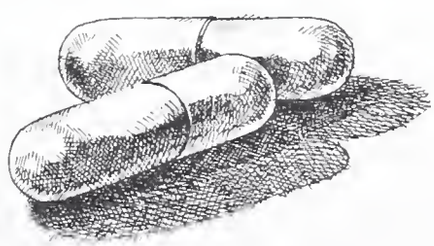

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Indicated as adjunctive therapy to control emotional and somatic factors in gastrointestinal disorders.

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Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. As with all CNS-acting drugs, caution patients against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving). Though physical and psychological dependence have rarely been reported on recommended doses, use caution in administering Librium (chlordiazepoxide hydrochloride) to known addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions), following discontinuation of the drug and similar to those seen with barbiturates, have been reported. Use of any drug in pregnancy, lactation, or in women of childbearing age requires that its potential benefits be weighed against its possible hazards. As with all anticholinergic drugs, an inhibiting effect on lactation may occur.

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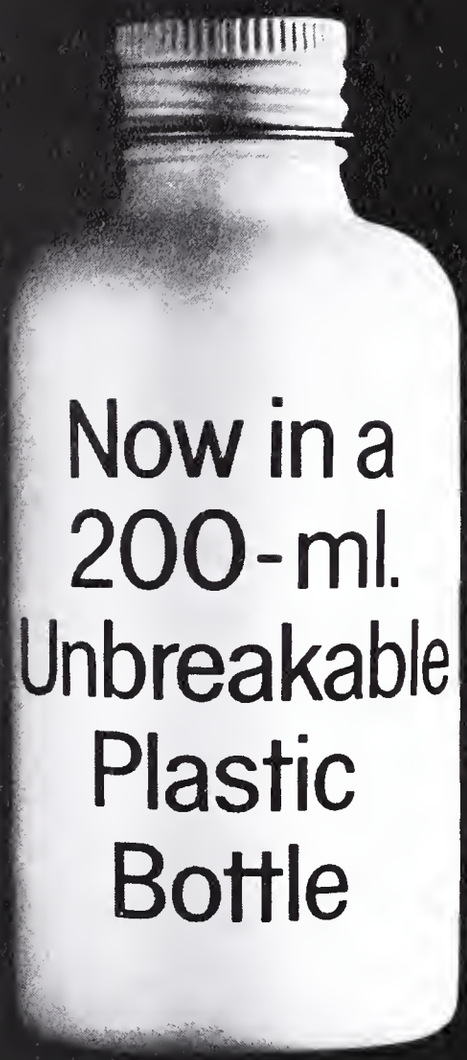

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ALASKA MEDICINE

Official Journal of the Alaska State Medical Association
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APPLICATION TO MAIL AT SECOND CLASS POSTAGE RATES IS PENDING AT ANCHORAGE, ALASKA

Volume 14 **January 1972** **Number 1**

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PRESIDENT'S PAGE

This issue of ALASKA MEDICINE is devoted to various views on the drug scene, including diverse opinions, statistical data, as good as can be obtained, reviews of authoritative books — in other words, an attempt to present a picture of one of our most misunderstood and maligned ills. It is true that organized medicine has paid some attention to our various drug problems from time to time over the years, but most often perfunctorily and frequently with a moral, judgmental approach. This is the first attempt in ALASKA MEDICINE to look at what I regard primarily as a medical problem, though necessarily with some legal implications, and such moral ones as individual consciences may dictate.

There seems to be an apparently invincibly ignorant core of people, both lay and professional, who insist on retaining a judgmental role on victims of all types of mental and emotional illnesses, especially those with problems of drugs or alcohol compounding their basic illnesses. Nevertheless, it is true that progress has been made in the past 25 years in improving the care of severely mentally ill persons and in accepting degrees of emotional illness as similar to those of predominatly physical nature — though not nearly enough and especially not enough in our own profession and in some social institutions such as welfare, corrections and mental health. I am, of course, not referring only to Alaska but to the nation as a whole and to many other nations also.

It seems to me that we as physicians must begin to face ourselves with questions or moral and value judgments about our profession and about our attitudes as professionals. We have preached our purity and pointed with scorn or mockery at our fellow professionals in law or education when they are caught in obvious hypocrisy. We cheer those attacking the courts as too lenient or too liberal, when we should be in the forefront of those changing the institutions and attitudes that breed crime and disease. Perhaps it is at this point that we are most vulnerable to our attackers who label us materialist or avaricious money-grubbers.

The "drug problem" is a good case in point. For many years we have ignored the horrors of heroin addiction in the slums or ghettoes of New York, Chicago and other large cities just as we ignored the slums themselves and the poverty that existed there. It was easier for us to do this because most of their inhabitants were black while we were almost lily-white. However, the increasing affluence of post-World War II America served to sharpen the differences which had been muffled during the Depression and put under the rug during the war. But gradually a few of our bright Caucasian kids and some blacks began opening Pandora's box in the late '50's so that the civil rights movement crescendoed in the early '60's — and many even have assisted the passage of our own native land claims bill which had been dormant for decades. However, when the actual physical stench of the South and of the Northern ghettoes reached the noses of our young people together with the metaphorical stench from the bribery, mendacity, corruption, and hypocrisy of what came to be called the "Establishment" many opted out, either feeling hopeless about changing things or else deciding not to become involved (like many of us) but having sufficient guilt feelings to necessitate some quenching. Thus, because alcohol was and is the tranquillizer of the Establishment, marijuana became the euphoriant of the protesters and their followers.

The problem was that marijuana, unlike alcohol, is illegal at all ages, and thus users, in order to obtain their dope, must deal with officially illegal and evil pushers instead of ordinary bartenders and liquor dealers. So, with the active cooperation of the Federal drug agencies and the massively uninformed public press and local police, the idealistic, sometimes militant, youth together with their multi-uninvolved followers were forced and "pushed" into the shadowy zone of the truly evil and illicit drug dealers who naturally pushed their most lucrative product — the addictive, expensive heroin. Then we were and are told that marijuana use leads to "hard narcotic" use without noting that the police and the puritans have made it this way by falsely depicting marijuana as at least as dangerous as heroin or Demerol.

The medical profession with its puritanical mores, at least for other people, went right along with this game. Drug addicts, like alcoholics, are difficult people to treat, they usually don't pay, they lie and cheat, and, most of all, embarrass the physician who has been taken in by their stories. This really does seem to be a great sin to many of our practitioners of any specialty who have been hoodwinked and thus have their tribal dignity affronted. It really does not seem to matter how many stores the person has robbed or how many prostitutions the female addict must undergo — how much self-degradation the addict must accept — just as long as his concealed cries for help do not fool a surgeon or an internist or general practitioner or psychiatrist and thus make us look like fools — which we may be.

May I suggest once again — for the umpteenth time — that we *are* fools as long as we insist on either ignoring the drug problem or in treating it as just a *drug* problem with no causes except morally bad ones. I can feel with Semmelweiss in Vienna in the 1850's when he suggested (foolishly, of course)

that doctors should wash their hands. I now feel we should wash our minds and try to look upon our patients as people even if they have had the misfortune to become pregnant without marriage or addicted or have some different attitudes than ours.

As may be noted in some articles in this issue, our clinic has had a fair amount of involvement with the Alaska's drug problems, in individual treatment, consultation, and community organization. Thus let it not be thought that this is written as a soft, do-gooding apology for drug abuse. Attempting to deal realistically means essentially a hard-nosed approach to the individuals involved, who tend to respect us more for this. As in other health programs, however, we also must adopt a realistic approach to deal with the causes of the individual problems.

—J. Ray Langdon, M.D.
President, Alaska State Medical Association

ABOUT THIS ISSUE . . . .

In this issue of *Alaska Medicine* we attempt to shed light on an important and widely misunderstood subject — the non-medical use of mind-altering chemicals, in current parlance "drug abuse". The opinions expressed are those of the authors and do not, in any way, reflect the attitudes or positions of the Alaska State Medical Association, officially, collectively, or individually. Neither do they reflect the positions of the Ad Hoc Joint Committee to Study Marihuana of the ASMA, or of the Greater Anchorage Area Management Group on Drug Abuse.

Physicians today find themselves, willy-nilly, in the middle of a huge social problem, which is part of the fabric of American society and which concerns them directly and unavoidably in their many roles as parents, voters, and taxpayers, as well as physicians. Even more intimately the problem concerns teachers, lawyers, legislators, clergy, police, and mediators of social services.Not much is known, and not much has been done in terms of what needs to be done and can be done, about the 'causes' of our young people turning to alcohol, tobacco, marihuana, LSD, speed, barbiturates, and heroin. But even casual acquaintance will show that the problems are complex and that the facts are contrary to many of our preconceptions. Moreover, the alternative courses of social action are not ideal, and any social action will necessitate compromise.

This issue of *Alaska Medicine* will give rise to more questions than answers; it is an attempt to identify the problems — how much of a drug problem does Alaska have; what are the correlations of drug abuse with personal inadequacies and psychopathology, with disturbed parent-child communication, and with social alienation; how harmful is marihuana in degree and in incidence; how effective or harmful are the drug laws; what are the possible approaches to the treatment of this 'social disease'.

As guest editor I have asked medical and non-medical authors to share their often controversial knowledge and opinons. Hopefully we can respect one another's ideas. Polarized attitudes are neither rational nor effective in the long run, and one should remember that few stands on medical or social questions can remain immutable for long. As with most major social issues, society must act on the drug problem before all the evidence is in. Even denial of the problem is itself an act with long-lasting effects.

—Frederick J. Hillman, M.D.
Guest Editor

Articles in this issue of *Alaska Medicine* were solicited. Opinions expressed are the responsibility of the guest editor and his contributors, and are not the official policy of the Alaska State Medical Association, nor even a representative sample of opinions of Alaskan physicians.

MARIHUANA – A SMOKE SCREEN

Frederick J. Hillman, M.D.

Why is a fifty-year old general surgeon editing an issue of *Alaska Medicine* about drug abuse? Some weeks ago, complacent in my ignorance and apathy, I happened to read Dr. Pillard's [1] review of Dr. Grinspoon's book *Marihuana Reconsidered* [2]. My curiosity was aroused and I sent for it. Grinspoon's balanced and heavily documented treatise suggested that my attitudes on marihuana (formed in the late thirties during the press campaign preceding enactment of the Marihuana Tax Act and molded since then by the Journal of the American Medical Association) were either naive or obsolete. This suspicion was reinforced by Prof. John Kaplan's book *Marijuana - The New Prohibition* [3], another carefully documented work covering similar material from a legal point of view. Considerable further reading about drug abuse and about marihuana since then, seems to justify several generalizations:

1. Drugs of all kinds are major social problems in Alaska. Alcoholism is the biggest problem. Marihuana is widely used, and misinformation about it is rife.

2. The "drug problem" makes no sense unless one distinguishes among drugs. Different kinds of persons use different psycho-active drugs to obtain different effects. The hazards of the various drug differ, sources of supply are different, and doubtless, effective methods of treatment and prevention will differ. Even when talking about a single drug, such as marihuana, one must distinguish among the experimenter, the regular user, and the chronic heavy user.

3. An individual's problem with 'hard' drugs or with the extreme use of marihuana is apparently often a symptom of problems in his personal life, disturbed family relationships *, or stresses of social status, race, and poverty. Another etiologic factor is the widespread alienation of youth from the culture of their elders. Still another seems to be the vulnerability of American youth to 'peer pressure'.

4. The literature on marihuana is voluminous but its quality is uneven. I know of no other field where the literature is so cluttered with clinical impressions, anecdotal reports, uncontrolled series, obsolete 'facts', stereotypes, bias, sloppy statistics, over-generalization, confusion of terms, non-sequiturs, and logical fallacies of all types. [4]

The controversy over drugs centers on marihuana. There is not space here for an exhaustive and documented account of marihauna as can be found in Grinspoon's and Kaplan's books. But since the marihuana laws are based on the alleged dangers of the drug to user and to society, I should like to pass along a few gleanings from the recent literature, with commentary as seems pertinent. As a preface I should state that I do not recommend the use of marihuana by anyone, have never tried it, and do not intend to.

Marihuana, like any chemical agent, including alcohol, aspirin, salt, and water, is potentially dangerous. How dangerous? The answer seems to be that, as it is now used by perhaps ten or fifteen million Americans, marihuana is a mild intoxicant, the hazards of which have been greatly overstated. Information widely disseminated by the Bureau of Narcotics and the American Medical Association [5] turns out to be highly debatable, if not unfounded. [16]

Dr. Solomon Snyder, Professor of Psychiatry and Pharmacology at Johns Hopkins University, in a recent book *Uses of Marihuana* [6] (endorsed by Dr. James L. Goddard, former Commissioner of the Food and Drug Administration, and by Julius Axelrod of the National Insitutute of Mental Health and 1970 Nobel Laureate in Pharmacology) summarizes the dangers of marihuana as follows:

> "The acute dangers of smoking marihuana are quite limited. Some people, probably only a small percentage, experience severe anxiety and paranoia which, however, are only short lived . .
>
> Marihuana is definitely not physically addicting in the sense that the opiates are addictive drugs. No one would deny that marihuana users are "psychologically dependent" on their drug. But such dependence is hardly more severe than the need for a morning cup of coffee. Of greater concern is the question of long-term effects of cannabis drugs . . ."

PSYCHOSIS –

One of the alleged dangers of marihuana has been acute psychosis. That such psychosis does occur is evidenced by many anecdotal reports [7, 8, 9, 10]; that such psychosis is very infrequent in the population of marihuana users can be seen from the reports of Dr. David E. Smith, [11] Medical Director of the Haight-Ashbury Medical Clinic, who found *no case* of primary marihuana psychosis in 30,000 patient-visits in a population, 95 percent of whom used marihuana. At San Francisco General Hospital 5000 acute drug intoxications were treated in 1967; *no* marihuana psychoses were seen. Lundberg [12], likewise, in Los Angeles found only three admissions following smoking marihuana out of 700,000 hospital

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* See the article by Dr. Ronald W. Ohlson on page 33.

admissions. These reports differ sharply from those out of Africa, the Near East, and India. They also give a quite different picture from the widely publicized, but statistically invalid, anecdotal reports [13] of disturbed American youngsters who also happen to smoke some marihuana.

ADVERSE REACTIONS

Adverse reactions of lesser degree have been widely discussed in the recent literature, but in general they are not sufficient to interfere with performance nor to induce the individual to stop smoking the non-addicting drug.

Bialos [14] at Yale reported that in a student body of 8500, out of 1020 patients seen for all conditions at the University Health Service, eleven appeared to be marihuana-related. *One* of these later dropped out of school. Probably an estimated 1500 of the 8500 had experimented with marihuana that year. [15] Bialos comments that the term "adverse marijuana reaction" is a complex one and includes value judgements as well as clinical observation.

To put the matter of adverse reactions into perspective, it is well to recall that marihuana is a non-lethal drug in human subjects. There has been no reported case of fatal marihuana overdosage in man. A high degree of safety has also been demonstrated with laboratory mice and dogs. The safety factor (lethal dose - effective dose) is about 40,0000 for marihuana, 5-10 for alcohol, and 10-12 for secobarbital. [16]

CHRONIC EFFECTS ON PERSONALITY AND PERFORMANCE

In the past the marihuana user has been sterotyped as idle, maladjusted, and often psychopathic. [17] Not only has the number of users increased dramatically in the past six years, (most of them one time or occasional experimenters), but the user has become respectable, and the old stereotype no longer is valid. Hochman and Brill [18] at the University of California at Los Angeles found that 34 percent of the students use marihuana at least weekly, and that 20 percent of the student athletes are users. They found no differences between users and non-users regarding scholastic achievement, interruptions of studies, probation, suspension, or grade averages. Twice as many users as non-users intended to go on to graduate school. These findings agree with other reports.[20, 21, 22, 23]

Lowinger [19] found that nine percent of psychiatrists attending the 1968 convention of the American Psychiatric Association were regular users of marihuana. At the UCLA School of Medicine over 75 percent of the medical students have had experience with marihuana. Lipp [24] found that of 1063 medical students at four schools in different areas in the spring of 1970, one half had used marihuana once, 28 percent were using it currently, and 10 percent had used it more than 100 times. (One wonders, if medical students, closer to pharmacology and physiology than they will ever be again, or practicing psychiatrists for that matter, cannot be persuaded about the alleged dangers of marihuana, what hope is there to convince students in high schools or colleges? One also anticipates with interest the impact of these marihuana-smoking physicians on their chosen communities a few years hence.)

On the other hand, Hochman and Brill [18] do not view marihuana as a harmless drug. "Indeed, we feel that it is a powerful, though subtle, agent which facilitates a large variety of long-term effects in the area of value systems, personal identity, and social mores." West [25] has described subtle personality changes in chronic users:

> "diminished drive, apathy, shortened attention span, distractibility, poor judgment, impaired communication skills, loss of effectiveness, introversion, magical thinking, derealization and depersonalization, diminished capacity to carry out complex plans or prepare realistically for the future, a peculiar fragmentation in the flow of thought, habit deterioration, and a progressive loss of insight."

West goes on, "There is a clinical impression of organicity in this syndrome which I simply cannot shake off or explain in any other fashion. What I have described is a clinical impression. That an arrest on a narcotics charge, and a felony conviction, can ruin the life of a young person is no clinical impression — it is a fact. I am deeply concerned about what our punitive laws have done and are doing to young people experimenting with drugs. At the moment this is a more acute problem than the question of long term effects of marihuana usage."

HEROIN

Regarding heroin addiction, Professor Snyder [6] says merely "The 'stepping-stone to heroin' theory has been pretty much debunked. It seems likely that the association between the two drugs is due simply to their being sold by the same peddlers." This explanation runs counter to the findings of sociologists Carey [26] and Goode,[27,28] who found that heroin users were a rarity in the marihuana-using subcultures which they studied, and that the two drugs traveled in different dealer channels both in New York and in Berkeley. Marihuana is a readily available, cheap, bulky commodity with a low profit margin. Many users are dealers in moderate amounts (1-10 kilograms), as much for convenience and safety as from desire

to make a profit. A dealer in drugs finds it more profitable to deal in hashish, LSD, amphetamines, barbiturates and heroin which are easier to transport. Goode[27] found no heroin addicts among 204 heavy marihuana smokers in New York. Carlin and Post[29] found no heroin addicts among 106 marihuana smokers in the University District of Seattle, although high percentages had used psychedelic drugs, 27 percent had tried opium, and six percent had tried heroin. Hochman and Brill at UCLA found no addiction in their entire sample of 2200 students. On the other hand, many reports[18,30,38] have shown that a heavy user of any drug is likely to experiment with many other drugs, including alcohol, tobacco, amphetamines, sedatives, tranquilizers, hallucinogens, and opiates. For example, Hochman and Brill found that 70 percent of the 44 heavy drinkers in their sample were also chronic marihuana smokers. Studies of the correlation of drug use patterns with personality and attitude inventories seem to show that the tendency to drug experimentation is the net result of personality and social factors which have nothing to do with the properties of the various drugs used. The chronic user who is a heavy 'experimenter' seems to be quite a different person from the moderate user.

PSYCHOLOGICAL DEPENDENCE

Marihuana is not addicting and does not cause physical dependence.[32] The question of psychological dependence comes back to its definition. Dr. Nicholas Malleson[31], director of student health at the University of London, noted "psychological dependence is an extremely imprecise, misleading, and unuseful term. In practice it means nothing more than 'I want it'." It is a term that can be applied to any pleasure giving activity, from a morning newspaper and a cup of coffee, to a symphony after supper. Marihuana is a pleasure giving agent to some persons. Of the persons who do try it, most use it a few times and give it up, some of the rest will become regular though infrequent users (2-8 times per month), and perhaps 15 per cent will use it several times a week. The daily user is rare.[33] Likewise the motivation for use varies:[11] many smoke it for relaxation; many younger persons use it to become intoxicated. The similarity to usage patterns of alcohol is striking. The differences lie in the preference of younger persons for a drug which they consider more pleasant than alcohol, safer, more easily controlled, non-addicting, and less likely to result in motor impairment, aggression, irrational behavior, or in hangover.

ON LEGALIZATION

There is not space here to discuss, as Kaplan does in his book,[3] the advantages and disadvantages of each of several possible schemes for controlling the distribution of marihuana. One should note, however, that 'legalization' can be applied to several legal models of control. Opponents of marihuana too often assume that by 'legalization' is meant free availability through normal retail channels (Kaplan's "sugar candy model") and then proceed to knock down the 'straw man'. Few responsible persons suggest this. Most persons who agree to changing the laws at all favor some system of licensing, with age limitation as with alcohol.

One way to clarify one's thinking on this subject is to make a list of realistic *desiderata.* Mine would start like this:

1. Moderate use of psycho-active agents by adults without medical supervision, including alcohol and marihuana. (*No* use would be desirable but is unrealistic).
2. No contact of youth with any drug-using subculture.
3. No contact of youth with the underworld.
4. Purity of whatever drug is used.
5. Legal penalties that are in proportion to the known (not potential) harm to society arising from misuse of a given psycho-active agent.
6. Early identification of disturbed children and disturbed families.
7. Easy availability of many types of counseling services for disturbed children and families.
8. Better and realistic education at home and in school regarding all drugs, not only psycho-active ones.
9. Absence of traffic accidents related to psycho-active drugs, including alcohol.
10. Cheaper enforcement of laws.
11. Freedom from legal interference in personal matters where there is no demonstrated harm to society.
12. Reduction in the alienation of youth.
13. Treatment of disturbed youth as sick rather than as criminal.

One should then decide if he is satisfied with the status quo, and alternatively how each item would be affected by a) stricter enforcement of existing laws, or b) changing present laws. If one decides on change, what changes would be desirable and effective (always considering costs along with benefits)?

One frequently hears the argument "Let's just enforce the laws. We just can't give in". But if the smoking of marihuana has become a widely accepted middle-class phenomenon, if large numbers of college students, medical students, and physicians cannot be persuaded that it is bad, even though illegal, and if 34 years of harsh legislation

have had no appreciable effect, what chance is there of further punitive legislation and stringent law enforcement being reasonably effective in the future?

Mannheimer et al [34] showed that 13 percent of the adult population of San Francisco (aged 18 and over) have used marihuana at least once. Moreover, "the majority of marihuana users appear to be reasonably conventional . . ." If the drug is used in Alaska to the same degree, there are perhaps 20,000 persons here who have used it (based on 1969 population figures). Estimates of marihuana usage nationwide runs as high as 20 million. If one takes a conservative estimate of 10 million, Alaska's share would be about 6000. The question then arises, how many policemen does it take to arrest 20,000 persons, or even 6,000? How many policemen is Alaska prepared to pay for? Realistic and practical law enforcement requires that the police not be asked to enforce a law that is unenforceable. If large numbers of these 20,000 are not being arrested, then the unfortunate ones who are, quite likely are being arrested for other reasons. If so, the police themselves are deciding whom to take in and whom not; the judges are deciding whom to punish and whom to let off with a suspended sentence. When large numbers of persons, including middle-class professionals, are liable to arrest and imprisonment at the whim of the police and the court system for 'other reasons', then we are no longer living in a democracy based on the rule of law; we are then well on our way to a police state. Is this the kind of America we want?

Many opponents of marihuana ignore Kaplan's [3] concept of weighing the benefits of both legalization and criminalization against their social and economic 'costs'; this concept, nevertheless, provides the main thrust of his argument. With the notable exception of law enforcement agents, a wide variety of persons who have studied the drug abuse problem regard the marihuana laws as harmful per se and the present legal penalties as being out of proportion to the dangers. Professor Rosenthal [35] of the University of Texas Law School states " . . . I am willing to say that on the basis of what we now know (and we do not know enough), marihuana, as defined, probably is the least or among the least dangerous of the hallucinogens controlled by federal law, and this should be relevant to the criminal laws governing its use and distribution", and further "The verified dangers of marihuana do not warrant such severe judgements as our legislatures have made".

The coordinator of narcotic programs for the California Department of Corrections, Weldon H. Smith, [36] said two years ago "Anyone with a minimal understanding of the term 'narcotic dependent person' could hardly stretch the meaning to include those who use marihuana . . . The growing evidence . . . indicates that experimentation with and chronic use of marihuana pervades almost every sector of our society that contains the age group 14 to 30 . . . Most of the individuals are functioning persons . . . who represent the strongest elements in terms of their potential contributions to our society . . . We should give serious consideration to recent recommendations that will modify this law, that will get the problem under regulation and control . . . "

The adverse effects of the marihuana laws are discussed at length by Kaplan. Two are of especial concern to physicians. Professors Hochman and Brill [18] of the UCLA School of Medicine state "The dissemination of incorrect, emotional, speculative, and unscientific propaganda on the subject of the most commonly used drug among American youth can result only in a further loss of credibility and relevancy by the medical profession". Dr. George Chun [37] of Long Beach puts it more simply "When young people hear lies about marihuana, they are no longer listening when the truth is told about more dangerous drugs, and the abuse of these drugs must be our main concern."

By any rational measure of a medical or social problem — persons dying, hospitalized, or crippled; murders, assaults, theft; lives blighted; children mistreated or abandoned; acute or chronic harm to the user of a drug, or to other non-users — marihuana appears to be less of a problem than alcohol, tobacco, heroin, barbiturates or amphetamines. In Alaska we have our share of tragedies from drug abuse. As the authors in this issue point out, much can be done to ameliorate them: new or improved and adequately funded social services, counseling services for disturbed families, havens for wayward youth, more realistic and effective education, training of parents in techniques for communicating with their children and with each other, a maintenance methadone program, activities to keep youngsters busy constructively, efforts to understand what youth is trying to tell us, and more effective control of the availability of all kinds of psychoactive agents. The worst of the adverse effects of the marihuana laws is that the controversy over marihuana has become a huge, dense smoke screen hiding our real problems. We have let our attention and our resources be diverted through blind fear into attempts to control a drug that apparently is uncontrollable (without greater cost than this country is likely to tolerate) and our attempts at control appear to be causing far more social havoc than the drug itself.

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"What, therefore, becomes an interesting paradox is our finding that students having the strongest identifications in social and political issues, the strongest involvement in cultural and intellectual activities, and the strongest concern with psychological and philosophical questions are the most likely to have experience with a drug which society as well as the university itself has deemed immoral and illegal. That is, activities which the university strongly encourages have been found to be related to a behavior which society strongly condemns. Why?

—Lawrence S. Linn, Ph.D.
Internat. J. Addict. 6:89, 1971

NEW VIEWS ON AN OLD DRUG

Aron S. Wolf, M.D.

MARIHUANA RECONSIDERED. By Lester Grinspoon, M.D. 443 pp., Cambridge: Harvard University Press, 1971, $9.95.

MARIJUANA - THE NEW PROHIBITION. By John Kaplan, Professor of Law, Stanford University 402 pp., New York, Pocket Books. A Division of Simon and Schuster Inc., $1.25 (originally published by The World Publishing Company, 1970).

Last August I communicated with the American Medical Association and the American Psychiatric Association to ask them for their bibliographies dealing with marihuana. The AMA sent a lengthy list but suggested that one should begin his reading with the two books that are being reviewed here. The APA's answer was simpler in that they suggested reading the two books and then perhaps using their bibliographies. From these answers one might assume that these works comprise the latest stable, rational, and scientific views dealing with marihuana. If both works are read in their entireties, one will find that they, by and large, present the same information and arrive at the same basic conclusions. How they compile the information, and how they arrive at the conclusions, however, are markedly different.

John Kaplan, author of *Marijuana - The New Prohibition* is a lawyer by training and is presently a Professor of Law at Stanford University. He arrived at his knowledge and expertise concerning marihuana while serving on a legislative committee to revise California's penal code, and especially its drug legislation. It is of interest to note, however, that when he presented his findings, and conclusions on marihuana, he was "summarily fired" from the committee. Professor Kaplan organizes his book in a very methodical and scholarly fashion. He sets out early in the book to show that the entire subject of marihuana and its use have been the object of scapegoating, and that marihuana has been made into a symbol that is representative of much of the underlying conflict within our contemporary American Society. He states "The issues include; the proper place of pleasure in our lives; the threat of radicalism, not only to society but also to our values; the proper degree of subordination of personal desires necessary to ensure survival of a civilized society — the issue of law and order, which not only includes respect for law enforcement in these difficult times, but also has overtones of both crime in the streets and racial violence; as well as the most important area that impinges on the marihuana issue, the generation gap". He goes on to say that one should tease the legal basis for marihuana legislation away from these highly emotional areas and that "The wisdom of a law should be determined in pragmatic terms by weighing the costs it imposes upon society against the benefits it brings". He then organizes the rest of the copious factual material in the book within this legal weights-and-balance framework.

Dr. Lester Grinspoon is a psychiatrist who has had additional training and experience both in the analytic and research fields and is presently director of research at the Massachusetts Mental Health Center and is associate clinical professor at Harvard Medical School. In accordance with his medical background his book *Marihuana Reconsidered* is written as an expanded medico-scientific treatise, presenting the history and pharmacology as entities unto themselves. It is only after the complete presentation of these areas that the social, and then legal aspects, of cannabis are dealt with. In the introduction to the book Dr. Grinspoon iterates his purpose: "My intention is to present a reasonably accurate and comprehensive account of the drug and its properties and to put into perspective its dangers and utilities". He goes on to add "It is important to do this now because use of the drug is growing explosively, and if we are to re-examine our present approach to the problem, we must try to divest ourselves as much as possible of the mythology, distortion, and hyperemotionalism surrounding the drug". Thus although one work uses a legal format and the other a medical model, both integrate history, pharmacology, sociology, mythology and the law within their scope.

It might be well here to encapsulate some of the factual information. History as discussed in both books is presented within two separate frames of reference. The first deals with the history and usage patterns of cannabis in the far east. This dates back at least to the time of Marco Polo. It is in his writings that etymological argument over the linkage between the words "hashish" and "assisin" is found, and it is from these writings that the connection between marihuana and violence is drawn. The contemporary history in the east begins with the report of the Indian Hemp Drugs Commission Report of 1892. According to Kaplan, despite its antiquity and relative obscurity, it remains the most complete and well balanced treatment of marihuana and hemp drugs generally. In this report and in subsequent reports of use in the Far East, differentation is made between the use of bhang and that of charas. Bhang being

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similar to our marihuana and charas being similar to what we know as hashish.

The American literature and history deals with two aspects of the plant and its use. First is the history of its introduction and growth in the 1920's, it alliance with ghetto life, and its identification with the rise of jazz and of the black jazz musician; as well as the rise of anti-marihuana sentiment following the repeal of prohibition in 1932, and the concerted attack on the use of the drug by the Bureau of Narcotics and especially Mr. Anslinger, the bureau chief, the latter leading to the 1937 Tax Act. Second is the post-1937 history, with initial emphasis placed on the 1944 La Guardia Commission Report. Among its findings, as reported in both of the present works are "that no proof existed that major crimes are associated with the practice of smoking marihuana, that marihuana smoking does not lead to aggressive or antisocial behavior, that marihuana does not alter the basic personality structure of the smoker or cause sexual overstimulation, and that no evidence of acquired tolerance for the drug exists". The La Guardia committee of two internists, three psychiatrists, one public health expert and the Commissioner of Health and Hospitals, and was a four study. The rest of the history deals with those scientific reports that have been published since 1944.

In considering the pharmacology one must give heed to an excellent critique of Grinspoon's book by Dr. Helen Nowlis in which she states that we must define what we mean by the word 'drug'. For under most pharmacological definitions Cannabis sativa is a plant which contains a number of chemical entities. Several of these entities are in the Cannabinol group, and in 1965 it was found that delta-tetrahydro-cannabinol is the psychactive isomer in natural cannabis. This isomer is found in greatest concentration in the flowering tops of female plants which are used to produce hashish or charas, and is found in lesser quantities in the leaves and stems used to produce marihuana or bhang.

Both authors deal extensively with reviews of the literature dealing with marihuana and aggression, marihuana and sexuality, and marihuana and the stepping-stone hypothesis to further addiction. In addition they both deal with the sociologic issues of pleasure drugs and review the literature comparing marihuana to alcohol and tobacco.

Despite the different courses that are pursued in compiling their data, both authors come to the conclusion that something must be done about the present marihuana laws. They both opt, after much discussion of the alternatives, to espouse the idea of dispensing marihuana through a government regulated and taxed distribution system which would have control standards, Grinspoon sums up by stating "Although it is clear that much more must and will be heard about marihuana and its derivatives, it is not so clear what must be learned before we are ready to embark on a more reasoned approach to the social use of marihuana. Given the facts that large segments of any population will use psycho-active drugs, and given the psycho-active drugs presently available (alcohol included) marihuana is the least dangerous. A fortiori we must consider the enormous harm, both obvious and subtle, short range and long, inflicted on people, especially the young . . . by the present punitive repressive approach to the use of marihuana."

Professor Kaplan arrives at the same conclusions by presenting his costs and benefits. He lists the benefits to society of the present legislation as;

1. The physiological and psychological and social effects of use, both adverse and non-adverse.
2. The acute and longer lasting effects of long term use.
3. The relationships of marihuana to aggression, dangerous drugs and heroin addiction.

He lists the costs to society as;

1. The often traumatic and anti-rehabilitative effects of arrest, conviction and/or jail on offender.
2. The contribution to alienation (because many of the young, rightly or wrongly, do not respect the marihuana laws).
3. The role of the present illegal treatment in impeding drug education efforts.
4. Questionable police practices stimulated by the difficulties of detecting offenses and obtaining evidence in the face of strong public and official demand for enforcement. He thus feels, and presents his case very cogently that the present costs to society far outweigh the benefits. Before settling on a 'licensing model' he also explores the use of other models, such as a 'medical model' using prescription, a 'vice model' as in the control of gambling, and a 'sugar candy model' or fee availabilty. He delves at some length into the costs of all these models, and again carefully weighing the pro's and con's, comes to feel that the licensing model is the most workable in the United States today.

Both of these books are extremely thorough in their approach to the subject. I also feel that it was invaluable to consider the data from both the medical and legal points of view, since the problem involved embraces both areas as well as the socio-psychological ones. I found Professor Kaplan's book to be the clearer and more concise of the two and perhaps the better one to start

(Continued on page 19)

WHY MARIJUANA?

J. Paul Dittrich, M.D.

"The fact is, once the terms are properly defined, there is no substantial doubt in the mind of any responsible person that marijuana is dangerous." [1]

"While there can be no question that the use of psychoactive drugs may be harmful to the social fabric, . . ." [2]

"No one, of course, recommends the use of marijuana nor does anyone deny that there are evil effects and consequences associated with using it." [3]

The above statements, which sound like quite persuasive arguments against legalization of marijuana use, are actual quotes of three authors who have used over 1000 pages in three separate books arguing in favor of legalization. Acceptance of these statements would seem to obviate the necessity of any prolonged discussion of whether marijuana is harmful or not. Without belaboring the point, marijuana is harmful because it causes a deliberate severance of the users contact with reality, it alters his ability to reason and act in a predictable and orderly manner, it modifies the appropriatness of his reaction to various situations, it renders him, if you will, temporarily insane. Any drug, any medicine, even the lowly aspirin, must be considered to be actually or potentially harmful. I do not believe that any responsible person would argue that there is not some harm, some danger associated with marijuana use. The only question is, how harmful? Is the harm caused to our society by the natural effects of marijuana use likely to be significantly deleterious to both society and the user, and is this damage outweighed by the good effects it will have? This is the only question that must be answered, and it must be answered objectively in all its ramifications if we are to arrive at a logical conclusion. It would seem that we can accept the admissions of these proponents of legalization as proof of it's danger, and proceed with our attempt to determine if, despite its harmful effects, it should be legalized.

It soon becomes apparent to anyone attempting to arrive at an answer to this question that most arguments, pro and con, are inspired more by emotion than by logic, formulated more by hearsay than knowledge, and defended more by righteous indignation than objectivity. There is no doubt that there have been and still are distortions, exaggerations and outright lies about the effects of marijuana. While most statements popularized in the past regarding it's harmful effects, such as its causing insanity, leading to heroin addiction, provoking violent and criminal behavior, and causing various physical maladies have now been shown to be for the most part untrue, the fact remains that marijuana, because of it's reasoning and behavior altering properties, still must be considered a dangerous drug. Why then, are we asked to make marijuana a part of our society? Why are we asked to accept it? What arguments are put forth in favor of legalizing it's use?

We are told that the present laws prohibiting marijuana use do not work, and therefore they should be abolished. The first part of this statement appears to be to a large extent true. But does the second statement necessarily follow? Our laws prohibiting murder do not prevent murders, our laws prohibiting rape do not prevent rape, and our laws prohibiting speeding do not prevent speeding. Do we there fore wish to abolish our laws regarding murder, rape and speeding simply because these crimes persist despite the presence of these laws? Total effectiveness is not the sole criterion for judging whether a particular law is good or bad. Our present regulations regarding drug use are, for the most part, carryovers from an era when marijuana was not the urgent social problem it is today and when the use of marijuana was the custom of various limited ethnic and cultural groups. Would we expect today's automobiles and highways to be effectively controlled by a system of traffic laws written in the 1930's? Of course our marijuana laws need revision. It is obvious that marijuana is different from heroin and that the crime committed by the pusher is different than that committed by the school boy using marijuana for his first time. The law in it's wisdom makes distinctions between the severity of various crimes in other areas, and it would not be unreasonable to expect it to do the same with regard to drug abuse. Progress is being made in this direction, and many states, including Alaska, have recognized this distinction. It would appear that further revision and refinement would be desirable in this regard. But what a damning indictment of mankind to say that, because we have failed to eradicate a problem, we should give up, we should quit trying, we should shrug our shoulders and justify our failure by saying it really wasn't that big a problem anyway.

We are told marijuana is no more harmful than alcohol, and I think this comparison is largely irrelevant. Marijuana should be considered on its own merits, and comparing it to other entities does nothing more than lead to endless debate and further cloud the basic issues. Granted, both are drugs. Both can significantly alter one's contact with reality and influence one's behavior. I think, however, that one significant distinction should be made. Not everyone who drinks does so to get

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drunk, but smoking marijuana is done for the sole purpose of getting high. One does not smoke marijuana because he is thirsty, or because he likes the taste of it, he does so to deliberately sever his contact with reality. It is entirely possible, as demonstrated by millions of people each day, to enjoy alcohol without getting high, but the marijuana smoker must get high to enjoy and fulfill his habit. Thus it is not a valid comparison to relate the use of marijuana to the use of alcohol. To be valid, we must compare the *use* of marijuana with the *abuse* of alcohol. Society has never condoned, in fact it actively condemns, the abuse of alcohol. But getting high is not an abuse or perversion of function of marijuana; that is its function. It is its only function. That is the only reason for using it. And this is a function, I think, which is hardly in the best interest of society to accept.

It seems strange indeed, that at a time when the full impact of the social and economic havoc being wreaked by alcoholism is just becoming fully known to our society, that marijuana should be gleefully promoted because it is not more dangerous. The fact that our society has a hungry lion roaming its streets devouring a certain segment of our population is hardly a logical reason for releasing a tiger to gobble up another segment on the basis that lions and tigers should have equal eating rights.

We are told that youth of today are different, that they are more knowledgeable, more intelligent, more aware and interested in society than those of former generations, and I believe this is true. We are furthermore told that, by our repressive attitude toward marijuana, we have alienated our youth, we have destroyed our communications with them, and they dislike and mistrust us because we have lied to them about the dangers of marijuana. There is, in fact, little doubt that we have exaggerated its harmful effects by statements that have largely been shown to be untrue. But why did we do this, why did we steadfastly oppose the use of marijuana, why did we paint such a dreadful picture of its effects? Did we do this maliciously and knowingly to deprive them of a harmless pleasure legitimately theirs? Did we secretly chuckle and bask in the warmth of the hilarious hoax we are playing on them by withholding it from them? I think not. I think our true ignorance of marijuana, combined with the love and concern for our youth, were the true motives behind our exaggerations. We knew not the real effects, and not knowing we feared, and fearing we exaggerated. And, we are told, for this heinous and despicable crime we are hated. Hardly, it would seem, the logical reaction of youth purported to have more intelligence, more awareness, more insight into life. Perhaps we loved not wisely, but too well, as we do when we tell our children that if they play with a butcher knife they will get cut, if they run in the street they will be struck by a car, if they go near the lake they will drown. These are all exaggerations of a similar nature, lies if you will, but hardly the genesis of hatred and mistrust when later found out to be untrue.

Conversely, let us see what in effect we are telling our youth when we propose legalizing the use of marijuana. "Young people, we are now enlightened. While we still know, and you do too, that marijuana is a dangerous drug, we now realize that it is not as harmful as we formerly believed. Even though it may be dangerous, we are going to let you have it because we want you to love us, because we want to reestablish our communications with you, and because we want to remove the mistrust you now have for us. We hope it will not cause you irreparable harm." Now if a group of young people purported to have more intelligence and more insight can't see straight through that little ploy, that desperate last ditch futile attempt to be loved, then I believe they fall far short of the intelligence and insight for which we give them credit.

The proponents of legalized marijuana neither offer a real explanation of how society's opposition to marijuana has alienated our youth, beyond stating that it is so, nor do they state how legalizing marijuana will remove this alienation, beyond expressing their opinion that it will occur. I think, rather, that our young people's distrust of the establishment and the marijuana problem are two separate symptoms of a general illness of our society, rather than one being the cause of the other. I fail to see how legalizing marijuana will somehow squeeze the LET'S LOVE SOCIETY trigger in our young people and reestablish our communications with them.

Perhaps the greatest tragedy of marijuana is that it mainly effects young people at the turning point of their lives, during the difficult transition from adolescence into adulthood. It is at this time that youth should be assessing themselves as individuals, facing the responsibilities of entering and finding their niche in society, in other words, maturing into adults. Unfortunately, it is at this crucial period that marijuana offers itself as a convenient copout, as a peer acceptable shirking from the responsibilities of adulthood and society and as a prolongation of the fantasy world of adolescence. How much easier, rather than face these problems of early adulthood, to pass the buck to Mary Jane and make them all disappear in a cloud of brightly colored flashing lights and strange haunting melodies. But unfortunately the clouds dissipate, the melodies die, reality returns and the problems remain. Our young person is older but no wiser, and maturity, if not prevented,

is at least delayed. And soon our young people arrive at an age when chronologically they should belong to society, but psychologically they do not. They are not ready. Unfortunately, there are no pharmacological short cuts to maturity.

The only purpose and effect of marijuana smoking is to sever ones contact with reality, to voluntarily become temporarily insane. The question is raised if this is inherently harmful to the individual or to society. Should society make laws, does society have the right to make laws prohibiting a person's voluntary, temporary peaceful withdrawal from reality? Is this really harmful to society? Is this an invasion of a person's privacy, as some people maintain, is it really any of society's business if an individual chooses to temporarily retreat into a fantasy world in the privacy of his own home and at no expense to society? Unfortunately, therein lies the rub, for society does indeed pay the bill. The social and economic burden imposed on our society by the abuse of alcohol belie the fact that this is purely a personal matter and that society has no stake in it.

Supporters of marijuana legalization stress the fact that people using marijuana tend to gather in congenial groups, indoors, and out of the public eye to enjoy their habit. The idea is thus somehow conveyed that this is an intrinsic characteristic of marijuana use and society need not fear that marijuana users will become a danger and a nuisance by enjoying their habit in public places. I do think, however, that we can extrapolate from its mode of use in its present illegal setting to that in a society where its user has no fear of arrest and punishment. The present illegality of marijuana use forces those using it into clandestine groups, reminiscent of the speakeasy of prohibition days. Legalization would remove this deterrent to public use, would permit people to carry their supply around in their pocket, and to use it in public places and on the highways. Is that fellow in the oncoming car smoking a Camel or a Mary Jane, and does he really see your headlights as such or does he see a brilliant display of flashing multicolored lights and try to get right in the middle of the action? Only your mortician knows for sure. There would appear to be little room for doubt that society does indeed have a stake in the solution to this problem and that society has every right to see that it is properly solved.

Articles encouraging legalization of marijuana use are replete with examples of successful business and professional people who use marijuana regularly and yet continue to function at a highly productive level in our society, and this is submitted as evidence that marijuana is harmless. Conversely, antimarijuana literature contains multiple examples of people in prisons and insane asylums who began their careers with marijuana use and this is cited as evidence that pot smoking invariably starts people down the road to crime and insanity. Undoubtedly, both groups exist, but I think the conclusions drawn from this are erroneous. I don't think people are brilliant or productive because they use marijuana, nor do I think our prisons and mental institutions would stand empty if marijuana did not exist. But I think that these two groups represent the extreme ends of the spectrum of our society, and could hardly be considered the average cross section of our culture. The first group would appear to be well motivated, well adjusted, mature, socially integrated and firmly in contact with reality. The second group would appear to be poorly motivated, poorly adjusted, immature, asocial and to have poor or no contact with reality. These differences can hardly be ascribed to the use of marijuana. But what about those people who fall somewhere in between, those who are reasonably well adjusted and socially integrated, who have a somewhat tenuous grasp of reality, but who have bubbling beneath the surface antisocial or criminal tendencies. What happens when marijuana removes the lid placed on these by conscience, by social, mental and moral pressures? Most people agree that marijuana does not have the power to instill new characteristics into a person's behavior or personality structure, but does have a definite tendency to uncover those already there. It would seem, then, that the behavior of a large segment of our population whose maturity, social integration and contact with reality are somewhat tenuous, would be significantly altered by the use of marijuana. It would furthermore seem that this alteration would hardly be in a direction beneficial to society.

In reality and contrary to many popular opinions, there seems little likelihood that legalization of marijuana use will result in large scale orgies of burning, looting and rape in our streets by legally turned on potheads. But here is also little doubt that legalization will cause further deterioration of our social structure. The tacit approval of its use given by legalization will do nothing to improve our culture or recapture our youth, but conversely will only serve to further alienate them, a luxury we can scarcely afford. We would appear to gain nothing and would undoubtedly lose much.

Rather than pin our hopes on the quickie solution of a pharmacological shot in the dark, why don't we be honest with ourselves and with our youth, why don't we admit our mistakes and shortcomings, why don't we analyze our present society, listen to our youth and work with them to improve our good points and eliminate our bad, This would seem to present a real challenge,

worthy of the best efforts of both factions, rather than accept the ultimate copout of legalization.

It would seem that a great deal of confusion has arisen about the marijuana issue because we are attempting to analyze it by applying the principles and investigative tools of the scientific method to this problem. Marijuana use is primarily a social problem and such issues lend themselves poorly to scientific evaluation. This is shown by the multiplicity of contradictory reports which are published under the guise of scientific investigation. Even the term marijuana must be accurately defined, as to the amount of active ingredient present. In a recent study of 36 samples purchased from pushers on the street which were alleged to be marijuana, laboratory analysis revealed that 33% contained no marijuana at all, and the remaining 67% had varying amounts of the active ingredient present.[4] It would appear that a significant number of people who claim to have smoked marijuana and described the effects of it were probably not smoking marijuana at all. Such consistent variation in the substance being investigated, plus the wide individual variation of its effects, make it difficult, if not impossible to draw a concrete and scientific conclusion regarding it's use. There would appear to be many serious gaps in our knowledge.

But simply because our beloved scientific method has failed is hardly a reason to abandon our common sense and say that the situation cannot be evaluated at all. Stripped of it's emotional aspects, the issue would appear to boil down to several basic points. Our society is being asked to accept a substance which even it's proponents admit is dangerous. We know very little of the short term effects of marijuana. We know even less of the effects of long term use. No one seriously claims any good effects from marijuana usage.

The present philosophy of the Food and Drug Administration, and the medical community in regard to release and acceptance of medicines and drugs, is that they must be proven harmless before being released, and if found to have harmful effects, their good points must far outweight the bad. Application of this principle to the marijuana question leaves little room for argument as to what our answer should be regarding legalization.

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"Just because alcohol is bad, it doesn't necessarily mean that marijuana is good. Just because the present drug laws are stupid, it doesn't mean that we don't require some body of law regulating the sale and use of intoxicants. And just because you have been lied to about the dangers of marijuana, it doesn't necessarily mean that it is safe."

Louis Jolyon West, M.D. in "The Marijuana Problem" by Norman Q. Brill, M.D., et al. Annals of Internal Medicine 73:462,1970

ON LEGALIZING MARIHUANA

Kenny Ashby, M.D.

Recently there has been much discussion concerning the legalization of marihuana. Unfortunately, most of the discussion which has been made public has been strongly in favor of immediately changing the law so that the substance can be obtained readily through normal retail outlets. Many physicians including myself are greatly opposed to this proposal.

Those in favor of legalizing marihuana put forth the argument that: (1) there is no evidence that the drug is harmful; (2) it is non-addictive; (3) if we make the drug available to everyone at low cost then the crime associated with the smuggling, selling, and use of marihuana will no longer exist; (4) prohibition of alcohol was a mistake so likewise prohibition of marihuana is a mistake. On the surface, this proposal definitely has some attractions. With legal access to the drug, certainly the pusher would suddenly run out of business. It is also possible that burglaries, robberies, prostitution and other drug-related crime might decrease. All users could then do their thing without the threat of arrest.

However, as good as these benefits might seem to some, they certainly don't out-weigh the dangers and problems of general marihuana use. Although there is no definitive proof that marihuana is harmful as is LSD and narcotics, evidence is definitely accumulating that it may very well prove to be harmful in certain instances. The physical effects of marihuana use such as conjunctival injection, photophobia, unsteadiness, lack of coordination, memory loss, slowed speech, tachycardia, increased blood pressure, increased blood sugar, distorted vision, bronchitis, and tracheitis are common knowledge. Drivers who smoke marihuana are dangerous. Tragic accidents have occurred because of marihauna intoxication. Under the influence of marihuana a driver's ability to judge speed and distance are impaired. It reduces ability to react appropriately to emergency situations. Vision is impaired, and the driver may be wearing dark glasses because of photophobia.

If marihuana were to become as common as cigarettes, how many more traffic accidents and fatalities would occur as a direct result of smoking 'Pot'? Would we then have a law to prohibit smoking marihuana while driving?

The possibility of cancer of the lung resulting from the chronic irritation to the bronchi cannot be discounted. Long term effects are not known. There have been many reports indicating possible mental abberations secondary to heavy marihuana use. However, these are only clinical impressions without controls. The FDA has only recently released standardized preparations for study, and these are now being made available through the National Institute of Mental Health. A very recent study by psychiatrists Kolansky and Moore[1] as reported in April 19, 1971 JAMA, however, leaves little doubt that moderate to heavy marihuana use leads to problems. They claim it may cause an interruption of normal psychological adolescent growth processes, or even psychosis. India declared hashish illegal after centuries of general use because of reports from their mental hospitals.

A frequently quoted argument for legalization of marihuana is that likening it to alcohol during prohibition. Some claim that legalization would have the same effect as legalizing alcohol. The difference here is that alcohol has been used by man since the beginning of existence; it has been in the daily diet of great numbers of people. When it was made illegal, these people refused to accept the law because it affected something they had grown up with. Marihuana has never been used to any great extent in our country until recently, and has never been legal. People accept that. If we make it legal and available and then later indeed find out we made a mistake, there will be no reckoning. People will refuse to give it up. Then another social problem as bad or worse as today's alcoholism will have been created.

There is a limited amount of pot available today. There is danger in making the drug available to everyone. If we make it legal, many people will interpret this as meaning it's all right to use at will, without harmful results. Thus, many will use it who otherwise wouldn't.

Marihuana smoking helps generate drug oriented groups in which the interest of a single member in other drugs such as heroin can quickly infect the whole group. The problem of hard narcotics, which is a serious problem now, could become much greater.

People who are well-adjusted are not likely to find pleasure in marihuana. The drug user, whether he admits it or not, is usually socially sick. He is a social cripple with weak underpinnings. People with a strong sense of purpose have no need of the marihuana crutch. People who use marihuana for pleasure tend to give up seeking pleasure in other ways. Thus, the very ones who shouldn't use the drug are the ones who end up with it.

There is now evidence that regular users of marihuana are decreasing. Dr. Charles Winick,[2] Director of the American Social Health association, states: (1) that drug use among high school and college students may be reaching "a kind of peak";

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(2) that studies of paired groups made last year indicate we may be approaching a situation where we will have fewer young persons starting drug use than we did in the preceding year; (3) there is evidence that U. S. college students are starting to shift from marihuana and other drugs to alcohol as a preferred mood modifying substance; (4) for the first time in ten years there is a decline in the number of new drug users in California.

In conclusion, there are many reasons why we shouldn't encourage the use of marihuana. Evidence is accumulating that moderate to heavy use may indeed be very harmful, may even cause psychosis. As long as there is some evidence of possible harmful effects of marihuana use, whether it be on the individual or society, any discussion on whether it should be legalized or not ought to be suspended several years until additional information is obtained.

Now that the FDA has released a standard preparation for use, significant studies will be forthcoming. The problem may even die out and cease to exist by the time definite answers are obtained.

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GRASS ON CAMPUS

Anonymous

The author of the following letter is a long-time friend, born and raised in Alaska, now an honors student at one of the better liberal arts colleges, intending to return to Alaska, who is intelligent, accomplished, travelled, aware of social issues, and not radical, alienated, or disturbed. The attitudes in this letter are probably typical of a large segment of marihauna users on college campuses today. —Ed.

Dear Doctor Hillman,

I was really interested to hear that you are doing a study of marihuana for the medical magazine.

I really think it should be legalized. It doesn't make any sense with all the real crime going on these days, for the police to spend their time hunting down harmless people who smoke grass.

I'm not heavily "into smoking" as they say, but I do enjoy it sometimes. Sometimes I smoke two or so times a week, sometimes *not* for weeks (like now when I'm studying). I don't consider it that big a thing. It's just fun at times, especially when I'm with groups of friends and listening to music. It makes it easier to get into the moment, to appreciate little things, especially in art and music; sensations are stronger. I would like to of course be able to experience this sort of frame of mind *without* smoking and the times when I am naturally stoned are usually the best, times when my mind is at ease, anxiety-free; I'm happy with myself and therefore can really enjoy each moment.

Also grass can heighten bad sensations, like insecurity and paranoia. So sometimes it is beneficial to smoke to get down all your defenses and magnify problems, to become really aware of them and be able to deal with them. In this way I think smoking can aid mental development.

But most of what grass is, is in the smoker. Young kids that don't know what they are doing can get messed up by smoking too much, just like they could with alcohol, or any other sort of stimulant used either to escape reality or to have fun. I think if a person is going to get messed up on drugs (I should say grass), he is the sort of person that would be messed up mentally anyway. So it worries me when I hear about marijuana in the junior high and grade schools because kids that age haven't begun to figure out their minds and don't know how to handle smoking.

I would also like it to be legalized when I realize that I myself could get arrested for possession of a "narcotic" and I wouldn't want to go through that, especially because of my parents. But I don't see why a stupid law of this stupid government should keep me from enjoying something that isn't injuring other people. (Actually that last sentence sounds rather childish — at least our government isn't as bad as the U.S.R.R. but that's irrelevant.)

Hopefully this information will help you out somewhat. I really don't know the percentage of students here who smoke grass but it's very common. My friends all smoke, some of them more than I do, but they seem to share my attitudes.

Good luck on your paper. It's really good to find a sympathetic person amongst my parents' friends. My parents, I don't think, are as open-minded toward grass. I'm not sure what they think of my smoking. I haven't seen them in a year but will be going home this Christmas . . . Merry Christmas!

(Signed)

STATEMENT OF JOHN KAPLAN TO THE NATIONAL COMMISSION ON MARIJUANA AND DRUG ABUSE

Gentlemen:

I will attempt to make the formal part of my statement as brief as possible. I have been informed that at least some of you have read *Marijuana - The New Prohibition* and wish to question me specifically about the propositions I advance there. Furthermore, no statement I can make now in any reasonable compass can approach the detail of a 380-page book on precisely the major issue with which you must grapple — whether or not this nation should replace the prohibition of marijuana with a licensing system somewhat similar to that we apply to alcohol.

My position is simple. If the marijuana laws worked, I would be strongly in favor of them. But they, like prohibition, do not work; they divide the young from the old and are propelling us to a national crisis of confidence of major dimensions. Therefore, they must go. Let me, however, make several additional points. *First*, marijuana is a dangerous drug. Should you attempt to spend a great deal of time and energy proving this, or indeed announce this discovery as a justification of your study, you will not be true to your commission. The fact is once the terms are properly defined, there is no substantial doubt in the mind of any responsible person that marijuana is dangerous. By this I mean that the drug can injure at least some of those who use it. Indeed, the only serious statements you will find to the effect that marijuana is not dangerous on examination turn out simply to mean that the danger of the drug is within the limits which our society sets for its legal, and indeed for its socially acceptable drugs.

Second: With respect to the dangers of marijuana, the real issue is not whether it is dangerous, but how dangerous it is. I will not attempt to go too deeply into this. First of all, I am not a psychiatrist; and secondly, each of the three psychiatrist members of the commission has written with some feeling on the issue. Nonetheless, one is struck reading the literature on marijuana that has any claim to scientific respectability — and, perhaps even more noteworthy, the surveys of what is known about the drug — that there is a surprising degree of unanimity. It is remarkable that the Indian Hemp Drugs Commission Report of 1894, the Panama Canal Zone Report of 1934, the LaGuardia Report of 1944, the Wootton Committee Report of 1968, the LeDain Committee Report (preliminary) of 1970 and the most recent report of the National Institute of Mental Health all say approximately the same thing. All of these reports point out overtly or inferentially that although to a considerable extent the long-term dangers of marijuana are not known, we know enough to conclude that moderate use does not seem to do the great majority of users any discernible harm. Moreover, a comparison of what we do know about marijuana from the considerable experience we have had with it, compared to what we would notice clearly on similar acquaintance with alcohol, indicates that no extrapolation of the dangers of marijuana could result in a state of facts where marijuana was more dangerous than alcohol. This would be so even if we resolved all of our present uncertainties in the direction of the most dangerous reasonable possibilities for marijuana.

This is not to say, I repeat, that the dangers of marijuana are negligible. We all know that the dangers of alcohol are not, and in all probability those of marijuana are not either. Nonetheless, once it is conceded that marijuana is no more dangerous than our other major recreational intoxicant, alcohol, a large number of the statements we presently hear about marijuana are shown to be unsupportable. For instance, granting the above, it is hard to argue that marijuana use is immoral; that education will successfully prevent marijuana use any more than it has alcohol use; that the damage to a small minority of abusers justifies in some moral sense the prohibition of the drug to those who would use it without discernible harm; and finally, that there should be an attitude of "I told you so" toward the youth of the nation every time a scientist reports he has found some people who are harmed by marijuana.

Third: The analogy between marijuana and alcohol has a further consequence. The repeal of prohibition did not imply a judgment that alcohol was not dangerous. Rather, it meant that a social cost of trying to enforce that unenforceable drug control measure far outweighed its benefits in improved public health. The same today is true of marijuana.

The sorry fact is that the marijuana laws are unenforceable — in the same sense that prohibition was unenforceable. If evidence on this is necessary, one need only note the surveys showing that approximately half of our entire college population has committed the serious offense of using marijuana. To this one might add the other figure,

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John Kaplan is Professor of Law at Stanford University, and the author of *Marijuana - The New Prohibition*. When asked if he would write a short summary of his views on the legalization of marihuana, he responded with a copy of this testimony previously given before the National Commission on Marijuana and Drug Abuse.

not as firmly based, but nonetheless gathered from numerous reports that approximately one-third to one-half of those who have tried marijuana use it on some kind of a regular — if infrequent — basis. The law has not prevented this in the past and shows absolutely no sign of being able to prevent it in the future.

This is not to say that the law does no good at all, since there are some who are deterred by the law from smoking marijuana and there are others for whom the law makes acquisition of the drug sufficiently difficult that they do not use it. On the other hand, to a sizeable extent those deterred or unable to obtain marijuana are not in the groups most likely to damage themselves with the drug. First of all, deterrence works best against those who are stable and rationally calculate the consequences of their actions. The dangers of marijuana are obviously at their greatest with respect to those who do no such thing. Secondly, the availability of the drug is highest with respect to the young. It is with respect to just these people that the most persuasive case for the dangers of marijuana can be made.

The unenforceability of the marijuana laws has caused and is still causing havoc in our nation. With the sole exception of the Vietnam war, the marijuana laws are probably the primary cause of alienation among our young in the sense that they are the clearest demonstration of what young people believe to be the hypocrisy of the older generation. I cannot prove this scientifically though I can state that, living on a college campus, it is so obvious to me as not to require proof. Should a commission be interested in proving this issue, I would recommend a number of social science techniques available for the purpose. Certainly, as a matter of presumption, we should not expect anything but resentment at a law which has turned over a third of young Americans into criminals.

This alienation has important consequences for law enforcement itself. Again, I cannot prove, but I suspect that no generation of young people since prohibition has grown up as profoundly distrustful of the police and the law enforcement apparatus as has our present younger generation. It certainly is undeniable that anyone who smokes marijuana cannot possibly consider the policeman as his friend and protector as I was brought up to do. Indeed, if one could graph somehow the hostility of young people toward the police with the increasing use of marijuana, one would find two sharply increasing and probably parallel curves.

The police by no means are the only major institution of our society which has been alienated from the young by our marijuana laws. Examine for instance, another major institution of our society — organized medicine. Just a few months ago, the President-elect of the American Medical Association was widely quoted to the effect that the Association had evidence that marijuana use caused impotence and birth defects. Over a week later he admitted that he knew of no such evidence, but that he had allowed the misrepresentations to stand because he wished to discourage marijuana use. As he put it, "If I am taken out of context and it does some good, I don't mind". When asked about the loss of credibility among the young caused by this type of authoritative misrepresentation, he said, "I'm tired of these phrases about credibility gap and such. We're talking about the morality of our country and the loss of respect of law and order and authority and decency."

In short, an attempt to support the marijuana laws led directly to the view that it was fine to mislead young people in order to get them to respect authority and decency. Because of this type of well-publicized incident — as well as the almost as well known lowering of scientific standards by the Journal of the American Medical Association to print articles asserting dangers of marijuana — it is extremely unlikely that even on issues where organized medicine is not attempting to compel respect for authority, that it will ever enjoy again the credibility with young people that it had before the marijuana laws become an issue.

The above points on the alienation of young people from the institutions of our society are somewhat indefinite and difficult to prove. There are, however, certain more easily verifiable damages caused by the marijuana laws. First, the marijuana laws in three identifiable ways contribute to the use of drugs which by any standard are far more dangerous than marijuana. First of all, since drug education is the most important long-term solution to drug abuse, it is tragic that the marijuana laws severely inhibit educating young people about the dangers of heroin, LSD, amphetamines, etc. The reason for this is very simple. Although education as to drugs other than marijuana can be extremely factual and yet very effective, the fact that drug education must also support the marijuana laws destroys a great part of its credibility. The reason for this — as grasped intuitively by the President of the American Medical Association — is that the only way to defend the marijuana laws to young people in our society is to mislead them about the facts.

The second way in which the marijuana laws increase the use of more dangerous drugs arises from the fact that by forbidding the legal sale of marijuana we have, in effect, given a monopoly of marijuana sales to drug pushers. This brings all those who would use marijuana (and as we have seen, the law seems helpless to prevent this) into

contact with a group which already risks severe penalties for selling marijuana, and, therefore, has every incentive to deal in higher profit items such as LSD, amphetamines, or heroin. One can liken this to what would happen if we somehow gave a monopoly of all coffee sales to one supermarket chain. Not only would their sales of coffee skyrocket, but so would sales of just about everything else they sold, because those who were in the store would be available for a hard sell on all other products. It is no different with illegal commodities and just as prohibition had to be repealed to get the mob out of the liquor business, marijuana will have to be sold under license by legitimate businessmen to get the drug pushers out of the marijuana business.

The third major reason why the marijuana laws cause the use of "harder" drugs involves the arrest of the marijuana user himself. Even though jail terms for marijuana users are in most areas no longer the order of the day, those apprehended for the use of marijuana typically spend a short time behind bars and at least some of them spend a significant time there. If so they are not only introduced to a society where all sorts of far more dangerous drugs are used and valued, but they are introduced into a milieu where these drugs are very often available. Anyone who has had extensive experience with heroin addicts knows some who had their first experience with heroin inside a jail. And where the original jailing occurred because of marijuana use, the irony is vastly compounded. I will not go on at greater length discussing here the costs of the marijuana laws. You gentlemen know my views and I will be pleased to answer any questions you have. My own solution would be that marijuana should be sold legally with taxation, age limits, and quality control every bit as alcohol has been since the repeal of prohibition. Of course, there is no reason to repeat some the mistakes of repeal. Thus, I would forbid advertising of marijuana in any way — just as any sensible social policy would forbid advertising of alcohol. Indeed, I can say with some confidence that it will be a very healthy thing for America when marijuana is sold in the same stores as is alcohol. It will be valuable for those who use alcohol to be confronted once and for all — and every time they enter a liquor store — with the fact that they are using a drug. And conversely it will also be healthy when our young people realize that in some sense they are no better than alcohol drinkers.

I would like to add finally, however, one further bit of information which was revealed only after the publication of my book. That is that a careful public opinion poll in the State of California showed that 46% of those between 18 and 30 wished the full legalization of marijuana while 7% of those above the age of 50 did so. If this rule is followed on this Commission, the vote will be heavily against the legalization of marijuana. I can only say that if it is, this Commission will be prolonging a national tragedy and will have contributed to the generation gap rather than done something to ameliorate it.

Thank you for your patience.

New Views On An Old Drug . . . .

(Continued from page 10)

with. I feel that these two books should be considered mandatory reading for every physician in Alaska. We pride ourselves as physicians in possessing factual knowledge about man and his physiology; it thus behooves us to know all that is possible about a drug that was used from the time of Homer until it was taken out of the Pharmocopeia in 1937 and which perhaps twenty million Americans have tried or are presently using. It behooves all of us then to become knowledgeable not only about the physiologic and pharmacologic effects of the plant and its cannabinol isomers, but also about the larger and more pressing social and legal issues. We cannot come to such conclusions with prejudice and we cannot reduce our prejudices, pro or con, without knowledge.

SOME CRIME WITHOUT VICTIMS

Robert H. Wagstaff

The concept of crime without a victim — that is, legislative morality — is not new to history and no stranger to the law. There are many laws in Alaska within this category. Chapter 40 of the Alaska Criminal Code is in fact entitled "Crimes Against Morality and Decency". How many know that cohabitation is a felony?

> A person who cohabits with another in a state of adultery or fornication is punishable by a fine of not more than $500, or by imprisonment in a penitentiary for not less than 1 year nor more than 2 years, or by both.

The Alaska Supreme Court declared in *Harris v State* (1969), that the term "crime against nature", the performance of which was then criminal, was too vague and overbroad for anyone to understand what it meant and therefore the prohibition of such actions was unconstitutional. In the opinion written by Associate Justice Roger Conner the court observed that:

> A re-examination of our entire regulation of sexual behavior by the criminal law may well be in order. The courts cannot, of course, perform such a comprehensive task, it is beyond the capabilities of only the judiciary. But the widening gap between our formal statutory law and the actual attitudes and behavior of vast segments of our society can only sow the seeds of increasing disrespect for a legal institution . .
>
> If the case at bar concerned private consensual conduct with no visible impact upon other persons, at least some of us might perceive a right to privacy claim as one of the penumbra emancipations of the Bill of Rights and the Fourteenth Amendment due process clause, or simply as one of the unenumerated-rights guaranteed by the Ninth Amendment.

Before the legislature can pass a law abridging any freedom of the citizen, there must be a legitimate governmental interest to be served thereby. Otherwise, the law is unconstituional as it would be arbitrary, discriminatory, capricious, and a denial to the group affected of the equal protection of the law.

The test of constitutional validity when we are speaking of victimless crimes is a balance — the right of the individual to be free and unfettered as guaranteed him by the Bill of Rights to the United States Constitution versus the public interest in an orderly society. Where this balance is judicially struck determines which morals society is legally compelled to abide by. As an example, criminal sanctions against homosexuality — one of the crimes against nature — entered our system of law as part of the Protestant Reformation in England. Like perjury, blasphemy, adultery and numerous other offenses, homosexuality had been an offense against ecclesiastical law. In medieval times the most heinous crimes were heresy, homosexuality and witchcraft — the punishment for any of which was death. Anyone suspected of heresy was automatically believed to be a homosexual, and vice versa. At that time the common name for both heretic and homosexual was "bugger" which is a corruption of "Bulgar" — medieval heretical sect which originated in Bulgaria. To assault and rob a heretic or homosexual was held to be a positive good, and to murder a heretic or homosexual was the supreme virtue. The church not only absolved the perpetrator of any crime against a heretic or homosexual, it encouraged such crimes by holding them to be saintly.

The Kinsey Report led to the opening of the campaign to end the persecution of homosexuals in the United States. The Wolfenden Committee recommended reform of all our laws relating to sodomy. The National Association of Mental Health recently stated unequivocally that "the law should not impose criminal sanctions for homosexual conduct committed in private between consenting adults". The obvious theory behind this statement is that there is no legitimate governmental interest unless non-consenting members of the public are affected. As has been shown by the various reports on the subject throughout the world, there is no correlation between homosexuality and propensity to commit crimes or heresy. Accordingly, there is no legitimate public interest to be served by its prohibition.

In the area of possessory drug laws an analogy can be drawn to the foregoing. The origin of the prohibition against possession of evil and deleterious substances has a similar source. To alter one's consciousness through the use of external substances is generally deemed to be unnatural and, as such, heretical and punishable.

The possession of hallucinogenic, stimulant, depressant and narcotic drugs is a crime in every state. The only victims of this crime are the possessors themselves. In order for a government to constitutionally make such possession unlawful there must be a supervening governmental interest above that of the individual's right to do whatever he likes. The Ninth Amendment to the U. S. Constitution which reserves all unenumerated

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rights to the people and the Fourteenth which requires the states to provide its citizens with the due process of law demand no less.

The United States Supreme Court in *Robinson v. California* (1962), ruled that the status of being an addict could not constitutionally be made criminal. Justice Stewart, in his opinion for the majority in *Robinson*, stated:

> The broad power of the state to regulate the narcotic drugs traffic within its borders is not here an issue. More than 40 years ago this court explicitly recognized the validity of that power: "There can be no question of the authority of the state in the exercise of its police power to regulate the administration, sale, prescription and use of dangerous and habit-forming drugs . . . The right to exercise this power is so manifest in the interests of the public health and welfare, that it is unnecessary to enter upon a discussion of it beyond saying that it is too firmly established to be successfully called in question."

Rather than discuss the difficult philosophical and moral issues of a legislative prohibition against evil substances and strike a balance between the rights of the individual and the actual interests of society, the Supreme Court simply said that the right to regulation was too firmly established to be questioned successfully. It is unrealistic to think that any court, with the present mood of the country, would take exception to this rule and actually examine the issues. Criminal penalties have been attached to the possession, use, manufacture, sale, failure to register at borders, failure to pay special taxes, and other offenses relating to drugs. The Supreme Court in *Robinson v. California* held only that the addict could not be punished as his addiction was in fact a disease similar to mental illness. The court reasoned as follows:

> It is unlikely that any state at this moment in history would attempt to make it a criminal offense for a person to be mentally ill, or a leper, or to be afflicted with a venereal disease. The state might determine that the general health and welfare required that the victims of these and other human afflictions be dealt with by compulsory treatment, involving quarantine, confinement, or sequestration. But in the light of contemporary human knowledge, a law which made a criminal offense of such a disease would doubtless be universally thought to be an infliction of cruel and unusual punishment in violation of the Eighth and Fourteenth Amendments.

Dissenting Justice White in *Robinson* pointed out that if a state cannot punish for the status or condition of drug addiction, how consistent with the Eighth Amendment stricture are those statutes that proscribe the use of drugs? It is apparent that an addict uses drugs because he is addicted to their use. For the same reason he will possess narcotics as well as the instruments for their use and may perhaps even sell narcotics to other addicts to support his own habit. He will sell, possess and use narcotics only because he is addicted to them, because he has the status of being an addict, a state or condition which cannot now be punished. As indicated, the court simply chose to ignore this problem and limit its decision to the facts before it.

In a subsequent opinion, *Powell v. Texas* (1968), the United States Supreme Court ruled that a chronic alcoholic could be convicted of the offense of being drunk in a public place notwithstanding the fact that he was addicted to alcohol. The court distinguished this case from *Robinson* and said that the addict in the *Powell* case appeared in a public place in an intoxicated condition and was not an addict strictly in private.

> On its face the present case does not fall within that holding (of *Robinson v. California*), since appellant was convicted, not for being a chronic alcoholic, but for being in public while drunk on a particular occasion. The State of Texas has not sought to punish the mere status, as California did in *Robinson;* nor has it attempted to regulate appellant's behavior in the privacy of his home. Rather it has imposed a criminal sanction for public behavior which may create substantial health and safety hazards, both for appellant and for members of the general public, which offends the moral and esthetic sensibilities of a large segment of the community. This seems a far cry from convicting one for being an addict, being a chronic alcoholic, being mentally ill or a leper .

It is only reasonable to expect one addicted to a drug to appear in public; as Justice White pointed out, it is reasonably predictable that an addict will use, possess and sell drugs. The reasoning of the court is not logically defensible. However, this phenomenon is not unique to this issue. The courts are composed of men who, as in the case of the United States Supreme Court here, are interpreting the Constitution of the United States. As men, they are political animals and reflect the feelings and pressures of their times. Their opinions are as much a product of their environments as anything else. A Supreme Court Justice does not spring forth fully armed from the brow of the Statue of Liberty.

The Alaska Supreme Court in *Vicks* v *State* (1969) ruled almost identically to the United States Supreme Court in *Powell* and held that, under the Alaska State Constitution, punishment of imprisonment for being an alcoholic in public is not unconstitutional. The court pointed out what was perhaps the true fear of a logical extension of the Robinson doctrine: if an alcoholic could escape being responsible for public drunkenness he necessarily logically could escape being legally responsible for burglarly, robbery or murder.

It has also been advanced that under an extension of the *Robinson* doctrine it is cruel and

unusual punishment to treat as a crime any aspect of the syndrome of addiction. What is so interesting is that the courts hold that addiction is not a crime but that simple possession — that is, a less abusive use of the drug — is criminal.

The courts, as they are continually wont to point out, do not legislate — they only interpret the legislative mandate and/or determine whether it fits within the constitutional framework. However, as the constitution is a viable conceptual document, what is unconstituional in 1971 may not have been unconstitutional in 1871. A difficult pill to swallow for those who seek ultimate truth. Chief Justice Warren Burger of the United States Supreme Court recently told a group of prospective lawyers that they should not seek social reform through the courts as they will be disappointed. Of course this depends on what you mean by social reform. However, with respect to existing drug laws it appears, at first impression, that it is unrealistic to expect the courts to declare them unconstitutional. It is too hot a political issue and one that probably will have to be resolved in the legislatures. Just after I wrote the foregoing sentence, however, I read the new opinion of the Illinois Supreme Court (*People v. McCabe* 10/15/71) where that court held that it was constitutionally violative of the Fourteenth Amendment's equal protection clause for the state legislature of Illinois to classify marijuana as a narcotic drug. The court in its opinion analyzes the merits, as it were, of the various narcotics and coments on marijuana:

> Observation to be drawn on marijuana is that it is not a narcotic and is not truly addictive. Its use does not involve tolerance, physical dependence, or the withdrawal syndrome. Physical ill effects from its use are, so far as is known, relatively moderate. Its abuse does not have the same profound ill consequences observed in the use of some of the other drugs considered. Its use does not singularly or extraordinarily lead to opiate addiction or to aggressive behavior or to criminal activities.
>
> Against the entire background of the drugs considered we judge that the classification of marijuana under the narcotics drug act rather than the drug abuse control act has been arbitrary. We do not find a rational basis for the classification, the consequence of which is that one first convicted of the sale of marijuana must without qualification receive a sentence 10 times greater than one permitted to be imposed on one convicted for the first time of the sale of drugs under the drug abuse act. The present classification of marijuana offends the equal protection clause of the United States Constitution and our new constitution of Illinois and was in violation of the former constitution of the state.

Undoubtedly this case will serve as a landmark in future attempts to have the marijuana penalties lessened and, hopefully, removed. This decision would have been impossible 10 years ago. The Illinois Supreme Court pointed out interestingly enough that:

> It is appropriate to note that we are not unmindful of the prior federal and state decisions which had rejected constitutional attacks on federal and state statutes classifying marijuana with the hard drugs.

The dissent to the majority opinion is, predictably, filled with the standard phrases to the effect that not enough is yet known and the evidence is not all in. The majority opinion obviously rejected these theories and felt that the time for action had come and specifically rejected all prior court holdings to the contrary. The opinion itself is really not that revolutionary. The New Jersey Supreme Court last year ruled that it was cruel and unusual punishment to sentence a first-time marijuana possessor to jail. A trend certainly is developing. The legislature in Alaska, of course, several years ago reduced the penalty for the possession of marijuana to that of a misdemeanor. The general policy of prosecutors in the state now appears to be consistent with the New Jersey Supreme Court opinion inasmuch as first-time possessors, absent aggravating circumstances, do not go to jail. Of course there are exceptions to this in isolated areas of the state — both geographically as well as intellectually.

The usual net effect of an adjudication of any criminality is incarceration. In cases of simple possession no logical *Robinson*-type objection to jail can be made as can be with addiction. Yet the enlightened trend is clearly to find harsh sentencing for simple possession of drugs unconstitutional.The true legal issue, therefore, lies not in what a crime is, but what the actual sentence will be. This real issue is seldom mentioned by the courts.

In penology today there is no realistic sentencing alternative to jail. The reason that there is little logic in court decisions relating to the use and abuse of drugs is simply that the criminal system operates in reverse. All efforts of the law are expended upon the adjudicative phase of guilt or innocence. Sentencing and post-sentencing procedures and phenomena, the actual and practical critical phases of the prosecution, are swept under the carpet. The rights granted to the accused must be extended to the convicted. The possessor of drugs is not now actually concerned with whether or not society condemns his act; he is only concerned with the possibilities of serving time in jail. Former United States Attorney General Ramsey Clark points out:

> It is one of the larger ironies of our time that, concerned as we are about crime, the one area

> in the whole system of criminal justice that offers the best opportunity to prevent crime is the most neglected. In fact, neglect in the criminal justice system reaches its zenith in the neglect of corrections. There may be no comparable neglect within the whole range of government services.

Of course, the type of reform that is necessary in American penology cannot occur overnight. Hopefully a few enlightened courts will dramatically start the flow in the other direction. However, it will take a massive judicial, as well as legislative, campaign to have any real net effect on our basic institutions of punishment that are the product of the hate, prejudice and spite since the beginning of civilization. However, certain interim measures could be taken to more realistically meet the facts of life. The person who is an addict, or simply possessing a drug for his own use, should not be punished in the conventional sense. If someone may use heroin it makes little sense to place him in an environment where drugs are prevalent and learn the additional socially unaccepted traits of homosexuality and violence. It is cruel and unusual per se to place someone in jail who is only possessing drugs. The only possible social interest to be served by making the possession of drugs unlawful is the deterrant factor to discourage others from using same. A simple citation with a fine will obtain the desired effect. This is the procedure with traffic offenders who constitute a greater real and present danger to society — albeit a more socially acceptable one. Incarceration is only puritanical punishment for possession of an evil substance thought to be dispensed by the devil.

However, if the addict or user actually commits an antisocial crime he can then be independently charged for this offense. The heroin user who steals can be prosecuted for larceny. To place someone in jail for simply possessing a substance, the possession of which is deemed to be illegal because it is thought to tend to induce criminality — when in fact there has been no criminality, is the epitome of legal and moral hypocrisy in a system based upon accountability.

Above all else it should be remembered that the Alaska Constitution requires that the objectives of penology shall be rehabilitation and the protection of the public. If possession of a drug does not involve any attendant criminal circumstances then the public is not in danger. The Supreme Court of New Jersey has recognized this with marijuana; the opinion should be expanded universally to cover all drugs. Oddly enough, Chief Justice Warren Burger shares somewhat the same opinion:

> What we must weigh in the balance is the rationality of a system that is all contest and conflict and offers virtually no treatment of what lies at the heart of the problem — a disorganized and inadequate human being who could not cope with life. Our system has too much sail and not enough anchor.

Victimless crimes crowd our court dockets. As far as alcohol offenses are concerned, the Alaska Department of Law has indicated that there will no longer be any state prosecutions for being drunk in public. This is only the first step. As long as people are put in jail for no more than possessing an evil substance, the legacy of the Protestant Reformation still lives.

> The line between what can and cannot be tested empirically is fuzzy, non-existent and irrelevant to most people. Therefore, not only is he who disagrees with me on scientific matters wrong and ignorant, but he who disagrees with me on matters of taste and style of life is also wrong and ignorant.
>
> *Erich Goode*
> *in "Marijuana and the Politics of Reality"*
> *J. Health & Soc. Behav. 10:92,1969*

REPORT FROM AN ALASKAN SMALL TOWN

Everett P. Wenrick

It was two a.m. but the doorbell was ringing. Early morning urgency arrests drowsiness: "Johnny got stoned and we can't handle him! You've got to help! Come on . . ." For several hours we literally held Johnny to the floor.

Several months before, Mel, who at sixteen ran away from home and was a speed freak, ended up in jail. The chief was decent. He said if a group of us would take care of him and be responsible for him he'd release Mel to us. Before we took Mel out six of us had a two hour "reality session" with him. It wasn't enough.

Edith was in her sixties and the apparent victim of some sort of psychosomatic illness. She lived from pill to pill: the little yellow ones in the plastic bottle, the large green and white ones, the brown oval ones, the mint green ones . . . On my pastoral visits the pills constituted one of the main topics for conversation. And then she would feel guilty and apologize for taking them.

For Judy the pressure to participate in the drug culture was too great for her fragile emotional system. The more she participated the shakier became her tenuous hold on anything she could call herself. She didn't really think I could help, she told me, but she had to talk.

If I were to continue my report from three years as an Episcopal priest in a small Alaskan town it would contain more stories like the above. But more than that, it would include stories of terror and hostility directed against those who were suspected of using drugs and of those overtly sympathetic to them; it would include a report of organized lawlessness by those responsible for upholding the law to run out of town the "hippies" or those associated with drugs; it would include the story of political upheaval and public scandal from the attempt to treat the drug problem merely as a police problem; and it would include the report of a town so gripped with paranoia that those who could speak in a more reasonable and knowledgeable way, such as those in the helping professions, including the medical profession, largely failed to do so.

In three years, however, I did notice one important change. Parents discovered, to their shock, that if they were to run the drug dealers and users out of town they would be running out their own children along with the transients. Parents were re-introduced to their children at the one or two successful drug seminars held at the school and the Teen Center.

Why report all this in a medical journal? Simply because from my perspective as a clergyman I see a great need for doctors and clergy to come out of their respective cloisters and address themselves concerning the drug problem to each other and to the community. Jamie Love, of Anchorage TOUCH, called the problem a "health problem" and that is, I think, one of the better definitions of the problem. But it is a *health* problem not simply a *medical* problem. All the other definitions that have been offered indicate the sweep of the problem; a "people" problem, a police problem, a social problem, a cultural problem, a spiritual problem, an individual ethical problem, and a chemical problem. By themselves none of the definitions are complete; taken together they probably approximate the truth of the matter.

I have heard doctors say that all problems are problems of chemistry and I have heard clergy say that all problems are spiritual problems, there are no others. Both are wrong. If both professions persist in this kind of myopia then we cannot address ourselves to the problem in any realistic way.

Every profession that I know is being called to come of age. Law schools, medical schools, seminaries, teacher training schools, and schools for the other helping professions, such as police training, are including courses in sociology, psychology, economics, and politics. This diversification annoys many and, admittedly, it has its dangers, but the greater danger lies in the ostrich-like stance of the professions.

A case at point is the story of Mel whom I mentioned earlier. His parents didn't want him back. There are no facilities in small towns to help Mel. Jail can't help. The hospital can't help. The school can't help. Welfare can't help. The churches could offer friendship, at least, but Mel scares them. We kept Mel for awhile; then our resources ran out. So Mel was taken to API in Anchorage, where he had stayed before and where he was listed as "psychotic". But they refused to take him back and Mel ended up back on the streets, and once again he became *everybody's* problem since he didn't fit neatly into the categories of any *one* agency's or profession's problem.

Except for the very rich the problems are compounded for the closet drug abuser, the business man or the housewife, simply because they most preserve anonymity and are afraid to turn to anyone. The doctor or the clergyman who respects confidentiality, and I think most do, are limited by that confidentiality in what they can offer. It is not enough, and their potpourri of professional codes and secrets (often confused with ethics) prevents them from seeking alliances with other professions. So some do nothing, and the rest "do what they can" which isn't enough.

From my experiences I would like to suggest several things that doctors and clergy can do to become more effective in their healing operations for drug abusers. I would think that these things would apply equally as well to the other professions; indeed, they must if change is to become significant.

In an article by Corinne Jones [1] taken from notes on a drug symposium conducted by David E. Smith, M.D. she lists four areas for effective community action involvement: 1) law enforcement, 2) research, 3) education for prevention, and 4) treatment. My suggestions have to do mainly with treatment but it is evident that all four areas are involved.

1) RE-DEFINITION. This is not a unique suggestion. But most definitions of the "drug problem" in the past have taken the form of dogma by the agency doing the defining. A continuing re-definition is required by a host of people representing different view points. Few researchers deny the complexity of the issue and therefore no definition can be simple or static. For many Alaskan communities a first step might be for doctors and clergy to get together for the *first* time and begin to loosen the professional masks that have served to keep them apart.

Definition involves the problems of the "chicken-egg" priority and the"causes-symptoms" syndrome, and these complexities tend to discourage people. What was once definite (but unhelpful) now becomes fuzzy (but with the potential for clearing), and therefore too hasty a conclusion or too final a definition should be avoided.

2) NEUTRALIZING SUSPICION AND FEAR. An atmosphere conducive to healing must be established so the job can take place. In the town I'm describing, the fears and hostilities prohibited rehabilitation. The problem should not be made larger than it is and if grass is "safe" or relatively unharmful it should be labeled as such. This is usually called education, but we can't leave the job to the schools. Clergy and doctors speaking out in the same public forum can do much to carry a message of knowledge and even hope to a distraught town.

3) ALLIANCE OF KEY WITNESSES AND PERFORMERS. In the town I was in, the City Council eventually appointed a committee to research the drug problem and to make suggestions. Most of the members of the committee were rightly appointed, but no clergy were named. Perhaps this is more an indictment of the clergy than of the City Fathers, but the fact remains that clergy (selective ones to be sure) are ones to whom the drug abuser does turn. This was certainly true in my case. Clergy are, then, key witnesses to the effects of the problem.

Witnesses tend to become diagnosticians and performers tend to become healers. Not only should doctors, clergy and others ally themselves, but the users themselves should be included. Communication increases confidence, which increases the healing performance. There was a popular bumper sticker found on local cars which expressed the cynicism and alienation of the community: WHEN IN TROUBLE CALL A HIPPIE. In an irony of the sticker's message may lie the truth that will make any alliance of professional people meaningful.

What I have outlined are mere sketches for guides to action. As I read it over, it sounds tame and hopefully five years from now it will be, but right now it can offer, I think, a real breakthrough in small towns and rural Alaska where suspicion, fear, and the lack of creative activity are the norm.

A lone worker in a hostile environment, whether he is a policeman, teacher, counselor, welfare worker, doctor, or a clergyman cannot go it alone. He is charged with coddling criminals at best and run out of town at worse. But with a movement towards defining the problem, towards the neutralizing of suspicion and fear, and towards the alliance of a host of people who give a damn (and I think we all do), the situation can change.

Few in the healing professions would claim that a patient can be coddled to health. The drug abuser's task is one of painful honesty with himself, and even with all the help he can get, he will still have plenty of sweat and work to do for himself.

REFERENCE

1. Jones, Corinne: *This Alaska, Aug. 1971.*

"..the important question that faces mental health personnel may not be "Why don't they stop using drugs?" but "Can we as individuals and as a society offer them viable alternatives to drugs?"

—Joshua Kaufman, James R. Allen, M.D., and Louis Jolyon West, M.D. in "Runaways, Hippies, and Marihuana", Amer. J. Psychiat. 126:720, 1969

DRUG SCENE IN ALASKA

(Mrs.) Mary Beth Hilburn

"Drugs are a people substitute and vice-versa."

Little or no research is available on the extent of drug abuse in Alaska. The figures I will use are the closest estimates available made by people working in treatment programs throughout the state and includes only those abusers of heroin. Jamie Love, who operates an Open Door Clinic in Anchorage, estimates there are 500 heroin addicts in Anchorage. Gail Shortell, Drug Abuse Coordinator in Fairbanks, estimates there are about 100 addicts with no treatment facilities available there as yet.

Many abuse problems exist, but heroin addiction is increasing in epidemic proportions and the most optimist reports give little hope for any change for a long time, despite what we may try to do to prevent it. Our best efforts may be able to decrease the increase, but we have to realize there will be those who feel our education and treatment programs have caused the increase, as those needing care become more visible. Once treatment programs are available, the number of persons in treatment will, of course, soar. The situation may seem bleak, but it is not hopeless.

People need to be aware of the potentially harmful qualities of all drugs, yet realize the benefits of drug use to young people. Drug use can provide peer acceptance, a chance for high risk-taking, a code (slang language) and uniform (fad clothes, hair styles). It's an instant culture. Legal drugs must be dealt with at the same time we deal with illegal drugs. That a substance is illegal is of far less importance to our young people than to us. The most dangerous and widely abused drugs are legal; alcohol is the most widely abused social drug. It can, of course, be *used* without being abused. Tobacco, which has no medical use at this time, has great abuse potential, and the dangers are well known.

Marijuana is the most controversial drug used today. I do not feel qualified to speak about all the aspects of the marijuana use and the impact these laws have on our young people. I would recommend Dr. John Kaplan's book, *Marijuana: the New Prohibition* to anyone who is interested. It is most interesting reading. He writes unemotionally and logically about this subject. My own feelings, which others have stated more eloquently, is that our time, effort, and money would be better utilized in the more serious abuse problems. Marijuana is probably incorrectly classified as a psychedelic; it is not a narcotic and is pharmacologically more closely related to the sedative-hypnotic nitrous oxide than anything else.

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Barbiturates, which are available through legal channels, are widely abused by adults and young people alike. As doctors are so well aware, the withdrawal from barbiturates is more dangerous and life-threatening than heroin withdrawal and should never be attempted without medical supervision. Laymen are not often aware that it is also synergistic with alcohol in that the effect of the two together is greater than either taken alone.

Amphetamines of all kinds are obtained from legal sources, and when injected cause hyperactivity of the subject and generalized central nervous system stimulation which can lead to violence. Coming off a "speed run" is called "crashing" and is dreaded by the "speed freak" because he becomes greatly depressed. Abusers of speed are always on the lookout for a sedative drug which can soften the crash and have found the best come down from speed is heroin.

Heroin is the drug most people think of when they hear drug abuse mentioned. In a memo I wrote after attending a conference in San Francisco during June, I dealt with the new heroin problem at length and would be glad to furnish copies of this memo to anyone who has not received it. Heroin is an all consuming life pattern which throws its users into contact with underworld suppliers. The average addicts must steal goods or prostitute themselves daily to support a habit in which greater amounts of the drug are needed daily to keep them feeling "normal". We are seeing more week-end and "recreational" use of heroin, called "chipping".

DRUG TREATMENT PROGRAMS

Treatment centers find that it is difficult to treat heroin addicts at the same facilities as other abusers because their life style makes lying and stealing a necessity. Drugs, equipment, and money are taken from doctors and others working in these centers.

Drug treatment centers need to be able to do "crisis intervention" for drug overdose and this includes alcohol. The physical needs of all these people abusing different drugs are similar, though later treatment and rehabilitation programs must differ as people and their needs differ. As an example, a man has an ulcer, the etiology of his condition is not similar to the condition of a woman recovering from the physiologically normal birth process, but certain needs of both are met in a hospital setting. They both may need anesthesia, rest, nutritious meals, and observation. Their

follow-up care will be almost totally different, as will their mental outlook and prognosis.

One interesting phenomenon of the "street scene" in drug abuse is the development of Open Door Clinics run by young, dedicated people who are doctors, nurses, social workers, or concerned non-professionals. They provide treatment or referral on a "no-hassle" policy. In Alaska, we have two: one managed by Jamie Love in Anchorage, and the Rainbow Clinic, managed by Jim Kelly through the Anchorage Youth Council. They both are expanding their programs to meet needs other than drug related ones.

TOTAL COMMUNITY PROGRAMS

Gail Shortell, the drug abuse coordinator for Fairbanks, wrote for and received one of the few community grants awarded by the Office of Education. The amount of the grant is $42,300. The focus of the proposal is on a Teen Center where young people can come in and discuss, with trained para-professionals, any life problem including drug-related ones. Young people, trained as counselors will staff this center. In the "Lower Forty-eight" these centers are often staffed with adults, but with our small towns we run into the problem of confidentiality and no perfect solution has been devised as yet to this problem.

There are community programs of various types in other areas of Alaska. One of the more promising types are positive peer pressure groups such as one small city has. The students keep each other off all hard drugs, are against alcohol and LSD. Marijuana is used there, as it is elsewhere, but is not considered a problem by the young people. I feel that a crisis-based, both feet approach there would result in more harm than good. The kids want to continue a self-help program and should be helped to do so.

One way of combating drug abuse has been a community-wide approach. Good community programs have some characteristics in common: The total community must be aware of the problems and their causes. So a community-wide education program is essential. In these programs, we emphasize that young people are capable of making mature decisions, but parents should be aware of what life problems their children are encountering. An often neglected aspect of the drug abuse picture involves the prevention of poisonings at homes of preschoolers and infants as well as the prevention of overdoses of heroin in older students and adults. This is one place informed parents can really help. Programs need to be developed in the schools, clubs, and other interested groups which include factual materials. I, and many others working with drug education, feel that the best prevention of drug abuse can be in providing quality and humane education to each child in Alaska. This may include innovations that nurture a good self-concept in a child which strengthens his resistance to dropping out to drug use, or other self-destructive behavior. Most potential drop-outs can be spotted by the third grade. Frightening, isn't it? What are the people of Alaska willing to do about this?

Involvment of all youngsters, native and non-native, is essential to the success of these programs. Get a group of these young people together and find out why they aren't involved and see if changes can be made that will make more kids welcomed and interested in school programs, churches, and social organizations. We need to be ruthless in looking at our concern for non-Caucasian students as well as Caucasian students. It can be so easy to say "we tried" when the effort was actually minimum to nil. A child who is alienated from society is a high-risk child, and a focus of high-risk youngsters can infect "safe" homes. Maybe as individuals, our impact would be greater if warm, loving people would do person-to-person things that make native, black, and materially less advantaged youngsters welcome in our homes, churches, clubs, and hearts. We may not have time to "let Joe do it, I'm so busy."

Some areas in Alaska still have a good chance of preventing an epidemic of drug-related problems. Prevention is not as exciting nor as measurable as the number of "freak-outs," "overdoses" and "drug deaths", but it's a lot healthier for the families of those potential tragedies.

The most important quality of good community programs is *people who care* what happens to young people, or not-so-young people, who are having problems and are coping with, or not being able to cope with, these situations. When the community becomes an extended family of aware people who care, any program has a chance to succeed.

Funds are now available from the Office of Education to develop community groups to train five or six people to be trained at the National Training Centers for two weeks. These people will return to their communities with help set up programs, and serve as catalysts to community action in the direction they identify as most beneficial. Four to five hundred communities from around the nation will be chosen to send representatives to the training centers, and several interested groups in Alaska have drawn up proposals.

USES AND ABUSES OF DRUG EDUCATION

Drug education has, over the several years, undergone many changes. In good faith, educators

have tried scare tactics, and used as factual, information that was of dubious worth. Other educators have favored decision making, (as if we could stop people from constantly making decisions about everything) positive peer pressure, "truth, the whole truth," and so on. Films have been shown to students released from regular classrooms and herded together to watch, then returned to their classrooms as an isolated experience, hopefully inoculating "them" against "it" — drug use.

I feel that all of these approaches have some good features. Anyone injecting a syringe possibly contaminated with pathogenic organisms should feel scared. Fear is not enough. Facts about drug use should be presented fully and truthfully. Facts are not enough. Cigarette smokers know smoking will shorten their lives, cause lung diseases and often cancer, but too many still light up. Decision making skills help, but not alone. There is not one easy answer. I wish there were.

Kindergarten through third grade children and their parents need to be aware of proper use of drugs only as directed by a doctor. Young children need to be protected from poisonous and corrosive materials through careful storage of these materials. Medicine cabinets need to be clean and locked.

Young people need exciting options to drug use, involvement in creative and non-chemically stimulating church or school community action programs. Schools which find a thousand dehumanizing ways to say, "no, we have a rule," need to examine who their schools are supposed to be *for — the kids.* Schools should not be run for the principal, for the convenience of the janitor, or to make things easier for the teachers. They should be run to provide the best possible individual opportunity for each child to learn a positive self-concept, develop skills in inter-personal relationships and to become a sympathetic, worthwhile member of the human race. He should be able to make his way, support a family, and raise children with these same *humane* human characteristics, also.

Parents need to allow children ways to maintain their internal integrity when they make a mistake, or want to change their minds, a human condition common to all of us.

Our values need to be explored. Do we really care for people, or are we showing that our greatest concern is for material objects. Can a child tell from our reactions which is more important, a broken dish or a broken arm? Our values will be taught intentionally or unintentionally.

If a home, school, and community do not provide warmth, involvement, a sense of self-realization, a sense of belonging, then drugs can provide these benefits. If there were no benefits, there would be no abuse.

Meaningful alternatives need to be available to every child. All the treatment centers in the world are not worth one prevention center, which might be a 4-H Club, Boy Scouts, Girl Scouts, religion, or an adult-student cooperative effort in any area. Hunting, hiking, model planes and rocket building, markmanship, bowling, motorcycle and bike safety and repair are all interesting subjects for life-long hobbies, but are rarely taught by schools. Perhaps some effort and money should be available to encourage these interests. Young people can work effectively in local programs on Hotlines, in Drop-in centers, in local government, and in community action unrelated to drugs. Environmental programs need responsible young people to help us all. They need to have important, responsible places in the life of the community. Their views should be sought and acted on when possible. Drug problems have been minimized by many non-traditional approaches developed and implemented by creative young people.

We have a needs assessment any community can modify and individualize to suit its own situation to explore some contributing problems and some possible avenues to solving them. If a community has no "drug problem" (a very unlikely situation, but often stated), it can certainly become a better, more humane, more interesting place for young people to grow up and for all people to live.

Treatment programs can range from first aid for an overdose, to long range methadone care, to talking down someone on a bad LSD trip. There is quite a bit written about all these areas of treatment which can be made available, as needed, but briefly some information about these programs might be helpful.

Treatment of the heroin addict is probably the most costly, most frustrating and least likely program to succeed. Many different modalities of care might be considered, among them are the use of cyclazocine, nalozone and methadone. Methadone, which is a narcotic, has many advantages for maintaining the addict which are preferable to continued heroin use. [1]

1. The medication is taken orally which gets the addict off the needle, avoiding the problems related with injections by unskilled persons, i.e., abcesses, hepatitis and other blood-borne infections.

2. There is no "rush" when methadone is taken orally.

3. It prevents narcotics hunger which seems to be a physiological change in the body which has nothing to do with the psychological dependence. Apparently, and more research needs to be done,

[1] Edward C. Senay and Pierre F. Renault, "Treatment for Heroin Addicts" *Journal of Psychedelic Drugs*, Vol. 3, No. 2 (Spring 1971), p. 48.

this hunger never goes away and is probably the cause of the high recidivism rate. Patients in some programs are given as high a dose of methadone as they can tolerate so if they attempt to experiment with heroin again, the heroin is unable to produce a "rush", which is generally considered to be the main reason for its use.

4. Methadone is relatively long acting. Thus, a patient on methadone is able to take the drug once a day on an outpatient basis and be gainfully employed. This does two things; allows the addict to contribute to society by getting off welfare programs, and he no longer needs to steal in order to support his habit which costs society many times over. An even longer acting synthetic narcotic may soon prove more acceptable in treatment. It is called methadol (alpha-acetylmethadol).[2]

5. While some moral objectives may be raised about keeping a person, perhaps for life, on an addicting drug, this point might be considered; if narcotics hunger, once established *is* a physiological reality, providing a substance to block this need, thus allowing a person to function in a socially acceptable fashion need not be considered more immoral than providing insulin to the diabetic whose pancreas is unable to fill his physiological needs.

Another treatment modality which has been tried and was mentioned in William Burrough's horrifying book, *Naked Lunch*, is the use of the narcotics antagonist *cyclazocine.* The objection most often cited about cyclazocine is that it does nothing for the narcotics hunger and soon patients drop out of treatment programs to satisfy this need by returning to heroin.

Naloxone is very expensive and short acting which makes it unsuitable for widespread experimental use at this time.

These treatment modalities are, of course, only for heroin and do nothing for the other drug abusers who may also need treatment and rehabilitation.

Detoxification is necessary for alcohol, barbiturate and amphetamine users. Treatment facilities need to be available to them and certainly their care needs to be individualized as to long-term, short-term, outpatient treatment and rehabilitation.

Rehabilitation programs should involve many agencies, among them might be Vocational Rehabilitation, Health and Social Services, Department of Labor and the Division of Vocational Education. During the actual process of rehabilitation the patient might be at home with counseling available to his family; in a halfway house or in a therapeutic community. The patient should be aware of the characteristics, advantages and disadvantages of each alternative and be given counseling help in choosing the one best suited to his personality and needs.

Halfway houses usually provide a supportive atmosphere, a place to live and allow the recovering patient to develop increasing confidence in his ability to function effectively without drugs. He may secure a job, re-establish ties with his family and develop new interests to fill his life which had previously been filled with drugs. People who have succeeded in these programs are available as role models, and run these houses.

Therapeutic communities vary in their approaches. They may consist of ongoing group therapy and encounter groups. They will often stress interaction, learning to accept responsibility and forbid the ex-user the luxury of self-pity or rationalizing past behavior. Some such as Synanon are so complete that they own industries, run their own schools, and become the whole center of life's activities for the addict or other drug user.

The need for these types of facilities in the state should be considered along with treatment programs. Other agencies should be involved in providing as much service as possible in their special areas in planning a comprehensive program of care for ex-users.

Law enforcement has the special task of eliminating the supply and availability of illegal drugs or legal drugs sold to illegal markets. Once an abuser enters the legal process, treatment and rehabilitation services should be made available to him if needed.

Long-term preventive programs might include urban renewal, improved health services, construction of housing and job training for school age young people and adults.

Projects aimed at helping individuals obtain and maintain feelings of self-worth and develop new attitudes and values about themselves and their relationships to others should be encouraged. One excellent example of this type of program is Project Careers in Juneau.[3] Young people bored and turned off by a traditional rule-choked high school are able to complete academic requirements and work at the same time. Many youngsters who would otherwise have been on the street with nothing to do, are maturing and learning to work and study responsibly because they are given real responsibilities.

The service this school provides might be explored to ascertain if similar programs should be developed in other towns in Alaska.

The best community and state-wide programs begin with people who care. Each concerned individual has a necessary function in program development and implementation. Conditions and needs vary by locality but basically once the problems are recognized, something can be done.

[2] Op. Cit.

[3] For more information contact Mr. Jim Hill, Director, Project Careers, 230 Fifth Street, Juneau, Alaska, 99801, Phone 586-6222.

A HEROIN WITHDRAWAL PROGRAM

Nicki J. Nielsen, ACSW
Jon F. Burke, Ph.D.,
and Joseph D. Bloom, M.D.

I. INTRODUCTION

In June, 1971 the Langdon Psychiatric Clinic found itself faced with an influx of people coming in requesting withdrawal from heroin. In the one week period from June 11 to June 18, eleven persons came to the Clinic requesting help in withdrawing from heroin usage. Over the previous year we had withdrawn a few addicts, but these were usually people who were involved in some sort of treatment at our Clinic. Since the early part of this year we have withdrawn or have in the process of withdrawal 120 persons.

It is hard to estimate the number of hard core heroin addicts in Anchorage. However, the Bureau of Narcotic and Dangerous Drugs has estimated that for every treated addict there are three more addicts in need of treatment. Using the figures of 120 persons that we have seen in the past six months, one can estimate that at least 350 more persons need treatment, which would indicate that there may be 500 or more addicts or at least addiction prone individuals in the Anchorage area at the present time.

II. DESCRIPTION OF THE WITHDRAWAL PROGRAM

When an addict comes for help he is told at the outset that we will be able to withdraw him only once from his heroin addiction. This has been done because any repeated attempts at withdrawal might be interpreted as methadone maintenance, a program which requires special permission from the federal government. (1) Currently any physician with a BNDD Number can use methadone for withdrawal as long as the methadone is terminated within thirty days.

The initial contact and screening process is done by one of the clinic secretaries who has developed a special interest and knowledge in problems of heroin abuse. She asks basic questions about the size and cost of the patient's drug habit, along with basic demographic data and whether the person is facing criminal charges. Next the secretary instructs the patient to obtain an urinalysis within the next 24 hours, and schedules the patient for interview with one of the psychiatric social workers. She also explains other requirements of our program. Patients are informed that they must come twice a week for group therapy and that they need to pick up their prescriptions in person on a daily basis or they will be dropped from the program. Following that discussion, the secretary then meets with one of the psychiatrists where the size of the addict's habit is translated from the street terms of spoons, balloons, slips, etc. into an estimate of the needed dosage of methadone and the addict is then given a one day prescription for methadone.

The initial social work interview is an attempt to explore with the addict the historical facts and some of the dynamic roots of his addiction. The focus is on helping the addict to begin to see his total commitment to heroin as a total life style and help him begin to come to grips with whether or not he wants to get out of the cycle in which he is caught. At that time the rules of the program are reiterated to the patient.

The process of physical withdrawal can be obtained in a relatively short period of time. However, we have tended to keep people in the program longer, up to two or three weeks, because we have found that the psychological addiction is far more serious and difficult to treat than the purely physical aspects. The addicts' group therapy program is also open to addicts who have finished withdrawal as well as persons in the process of withdrawal. In addition to the three authors of this paper, other persons who attend one of the two weekly sessions of the group include Dave Pretz, Vocational Rehabilitation Counselor; "Ed", a former addict who is on the staff of the Open Door Clinic; and Shirley Henderson, the secretary who has primary responsibility for coordinating prescriptions and keeping records about the addicts. In addition to the required procedures for the addicts, we also offer them other kinds of assistance as is deemed feasible (such as individual therapy in a few cases) and help with vocational planning with Mr. Pretz.

As the elements of our program began to fall in place, we met in June with people from several agencies, (Division of Family and Children's Services, Office of Vocational Rehabilitation, Alaska Children Services, Alaska Medical Laboratories, Medical Arts Pharmacy) and explained our feelings of the need for such a program and described our plans to them. At that time the Office of Vocational Rehabilitation agreed to finance the bulk of withdrawal patients for a three month period of time. This extended through September, 1971. The three months was based on the anticipation that our application process for funding for a methadone maintenance program would have been decided on. To date we

have not heard regarding application for a maintenance program and much of the financial expenses for this program have been borne by the Langdon Clinic.

III. THE "NARA" PROGRAM

In addition to our formal withdrawal program, we are also involved in a federal program for addicts, Narcotic Addict Rehabilitation Act. Since October, 1968, the Langdon Clinic has functioned as the aftercare agency in Alaska for this program. Basically the NARA program is 42 months long and involves an initial period of hospitalization of up to six months at one of the federal contract hospitals (formerly in Fort Worth, Texas or Lexington, Kentucky, but now hospitalization for Alaskans is at the Salem, Oregon State Hospital (2) followed by a three year program in the community such as Anchorage. The procedures for persons interested in this program are: 1) An interview with the U. S. Attorney in Anchorage who discusses the program with the prospective patient and then obtains a court order committing the person to our Clinic for a 15 day evaluation. 2) During the evaluation period we do a diagnostic workup which includes a social history and psychiatric evaluation; in addition the addicts are expected to attend group twice weekly. A physical examination is also done by another local physician. They are maintained on methadone, if necessary, during the evaluation period. If found feasible for the program, they are committed to the NARA program by the Federal Court and sent to Salem, Oregon. During the after care portion of the NARA program, following the patient's return from the hospital, the patient is assigned a therapist who sees him once a week or more often individually; and in addition, he may also be assigned either to the addicts' group or another group more appropriate to his expressed needs. We can help with housing with NARA funds, if needed, and an individual may be referred to the Office of Vocational Rehabilitation, if a portion of their total problem seems related to vocational adjustment.

IV. OBSERVATIONS AND EXPERIENCES TO DATE

The following data come from a 14 point questionnaire developed for this paper. The first 100 case files of addicts seen in 1971 were studied. Since the questions were designed after the persons were seen not every question could be answered and the data following do not always total 100%.

The sample consists of 69 males and 31 females with an age range of 16 to 64 years. The median age is 22 years and 65% of the persons average age 24 and under and 17% are age 30 and over.

58% were single, 20% married and 50% lived either with parents, spouse or family. Only 8% live alone, information on 23% was lacking and the last 19% lived with friends.

75% are Caucasian, 17% Black, 4% Native, 2% Mexican-American and on 2% we did not have the data available.

75% of the total sample had lived in Alaska more than five years and 9% of the total have lived in Alaska between two and five years. Only 11% of the population have been here less than one year.

36% were employed during the withdrawal and 38% did not list an occupational preference.

Of the 100 individuals, 42% of the persons completed the withdrawal program.

At least 62% claimed no criminal charges pending, 20% claimed current charges. Information was unavailable on 18% of the persons.

Table 1: Heroin Usage

	Current Steady Use of narcotics: Nbr. of Patients	Length of time since first use of narcotics: Nbr. of Patients
Less than 3 months	16	3
3 to under 6 months	19	3
6 months to less than 1 year	22	9
12 months to less than 24 months	11	14
24 to 36 months	16	16) 61%
more than 36 months		45)
Don't know	16	10
	100 = 100%	100 = 100%

As can be seen from Table 1, 61% of the persons in the sample first began heroin usage more than two years ago. However, intermittent usage is shown by the fact that only 16% admitted to being constantly using for more than 24 months. 36% of the individuals were spending less than $100.00 a day.

Once they had either quit or finished the withdrawal program 23% made repeated requests for methadone, 8% continued in some form of treatment with the Clinic. Another 7% went on the NARA program and about 60% had no further contact with the Clinic as of mid November.

In trying to draw some meaningful conclusions from the data described above, a chi square analysis on some of the data was carried out. Using this method we found that those who were employed had a slightly better chance, statistically, of completing our withdrawal program, i.e. coming in regularly and being completely withdrawn by decreasing amounts of methadone. (3) However, in using the chi square to evaluate whether having criminal charges meant a

person was more likely to complete the program, we found that having criminal charges was not statistically related to completion of the withdrawal program.

V. CANDIDATES FOR METHADONE MAINTENANCE

In our sample of 100 individuals we attempt to isolate a group of patients who might be considered for a methadone maintenance program using the guidelines provided by the Federal government for approved programs. We found 61 individuals who had heroin usage of greater than two years. We then divided this group of 61 persons into two groups, a primary group and a secondary group, based on their continuous use of drugs. The primary group numbered 28 persons who had used narcotics *steadily* for more than one year at a time when they came to the Clinic for withdrawal. The secondary gorup numbered 33 persons whose current steady use of heroin was less than one year at the time they came for withdrawal. The following table shows several of their characteristics.

Table 2: Characteristics of Possible Methadone Maintenance Patients

		Primary Group N = 28	Secondary Group N = 33
Sex	Male	13	25
	Female	15	8
Length of Use	Less than 2 years	2	5
	More than 2 years	26	27
	Don't know	0	1
Criminal charges pending	Yes	9	5
	No	17	23
	Don't Know	2	5
Completed program	Yes	9	15
	No	19	18
Employment	No occupation	7	8
	Employed	8	13
	Unemployed	13	12
Daily cost of habit	Less than $100.	12	10
	More than $100.	13	22
	Don't know	3	1
Race	Caucasian	15	27
	Black	8	5
	Native	4	0
	Mexican-American	0	1
	Don't know	1	0

In reviewing the characteristics of these two groups it is striking to note that for the first time the ratio of males to females is reversed in the primary group. The 15 females in the primary group represent 48% of the total female population in the sample. Hence, from our original sample one can infer that of the females who came for withdrawal a signficantly larger proportion are more likely to be prime candidates for a methadone maintenance program.

Another observation is that the proportion of persons having a habit of less than $100.00 a day was greater in the primary group of persons who had been using heroin continuously for at least one year. It appears from the figures that those in the primary group are less likely to complete the withdrawal program than those in the secondary group. Further, the people using heroin for less than one year have about a 45% chance of completing our withdrawal program while those who have been strung out more than a year have only about a 32% chance of completing the withdrawal even though many of that group have smaller habits dollarwise. This proportion also seems to correlate with employment as only 32% of the people in the primary group were employed and about 40% of those in the secondary group were employed.

VI. CONCLUSIONS

1) There clearly *is* a heroin problem in Anchorage. A withdrawal program as outlined can help meet some of the problem. However, there are many people who are poor risks in such a program and that many of these are people who would be eligible for a methadone maintenance program if one were available in Anchorage. From the above data we would feel that a methadone maintenance program should be developed as a priority program and for at the least 50 patients.

2) There is a need for additional funding for programs with addicts as the majority of addicts are not employed and cannot pay for the kind of services that ideally are needed in a treatment program for them.

3) There is a clear indication for joint mental health and rehabilitation focus on both a withdrawal or maintenance program.

4) Physicians in solo practice would probably find being involved with a *large* number of addicts a very difficult task and thus probably should not attempt to start any large scale withdrawal program by themselves.

5) A treatment program for withdrawal from heroin needs to include more than just prescriptions for methadone. There is a need for additional services such as:

a) Group sessions aimed at helping addicts deal with what being addicted means in their lives.

b) A special program for vocational evaluation and training when indicated through the Office of Vocational Rehabilitation.

(Continued on page 39)

PARENT EFFECTIVENESS TRAINING

Ronald W. Ohlson, Ph.D.

Is there a central ingredient in the phenomena of drug abuse? Many factors appear to enhance the appeal of drug usage in young people. Social reinforcement from the peer culture is a powerful factor. There is some evidence that prohibition of drugs merely increases the drive strength for the behavior, as if to imply: "If everybody is so *excited* about how bad it is, it has to have a powerful effect on you!" However, in many hours of counseling various people involved in differing levels of drug use (and abuse), I have found a universal ingredient: I have yet to find a drug abuser who possessed a communicative relationship with his parents. In most cases the effect is generalized to the extent that these people are unable to sustain a meaningful relationship with *anyone* over a long period of time.

When children learn that they are simply unable to communicate their own needs, feelings and thoughts to their parents, they have no choice but to withdraw to avoid the pain of rejection and unfulfilled needs. They thus develop a non-communicative, non-selfdisclosing, deviant life style in order to cope with that pain.

My hypothesis, yet to be experimentally verified, is this: If a communicative parent-child relationship is not established by the time the child is confronted with the teen-drug culture, he will have developed a life style of deceit, rebellion and coping behavior, the needs of which are met by the peer culture, and he will be lost to the parents, psychologically if not physically, perhaps for a lifetime.

What is desperately needed is a systematic, simple preventive approach, not to drug abuse, but to parent-child relational disorders.

Thomas Gordon, Ph.D., was a practicing clinical psychologist in Pasadena in 1962. In his experience with children and parents, he found that, first of all, the teenagers that he was seeing had been brought to him far too late. Their maladaptive behavior patterns were firmly fixed and difficult to modify. Moreover, drug involvement intensified the life styles based upon those behavior patterns; and, if drug dependency had developed, the process in many cases became irreversible.

In addition, Dr. Gordon found that most parents resisted getting involved themselves in the therapeutic process in order to look at their child-rearing practices. Most parents preferred to drop the child off at his office, hoping that the "Doc" would fix him up and return him home repaired and remodeled, much like they would drop off their ailing car at the local garage.

Over the years, as parents described what was going on in the home, Dr. Gordon began to hear common themes. While the children were very difficult and dissimilar in both personality and symptomatology, almost every parent seemed strangely similar to others he had seen. All had a surprisingly similar philosophy of child-rearing; all used similar approaches in discipline; all had confusions about parental authority and all talked with children in destructive ways. Most significantly, all had the same dilemna about whether to be strict or lenient, restrictive or permissive, tough or soft. While he found himself hearing similar themes from these parents, Dr. Gordon also found himself giving similar advice and instructions. He was further impressed by the fact that these parents did not seem to need *therapy* as much as they needed *education about human relationships*. As a result, Doctor Gordon decided to attempt to work with groups of parents who had similar child-rearing problems, thus enlarging his sphere of influence. Moreover, he changed the entire focus of his private practice to facilitate a preventive approach rather than a treatment-oriented approach to relational disorders. He formulated his ideas and philosophy into an eight-week course which he called Parent Effectiveness Training,[1] utilizing as its focus the critical factor of the parent-child relationship.

The key principle in P.E.T. is the *relationship*. In order for this program to succeed, both parties must desire to develop and maintain a communicative relationship. Without a commitment to relationship, this program is greatly weakened. But it is a most powerful method for modifying behavior, including drug abuse, if both parties need and value their relationship.

The course is divided roughtly into four phases. The first could be called the *diagnostic phase*, as parents are taught to differentiate between those situations in which the child is making it difficult for himself to *meet his own needs* as a person, separate from the parent, and those situations in which the child is making it difficult for the *parent to meet his own needs*. This differentiation is most critical because the communication process can be destroyed and needless tension injected by an improper diagnosis of *who owns the problem*.

Dr. Ohlson is Senior Clinical Psychologist, Division of Mental Health, Department of Health & Social Services.

For further information about Parent Effectiveness Training write Ronald W. Ohlson, Ph.D., Alaska Psychological and Educational Consultants, P. O. Box 3033, Anchorage, Alaska 99501.

In the second phase of the program parents are given skill-training in those forms of verbal communication that have been experimentally demonstrated to be most effective in helping another person overcome difficulties in meeting his own needs. Carl Rogers developed the technique of non-directing counseling which has been validated by Charles Truax and Eugene Gendlin at the University of Arkansas, and the University of Chicago. Parents actually learn how to become effective non-directive counselors by developing the skill of "Active Listening", empathic open-ended questioning and methods of keeping the locus of responsibility with the child who owns the problem. Curiously enough, many experienced therapists report that their own therapeutic approach has been enhanced by taking this course because it gives opportunity for practice and feedback in the learning process. Parents have been shocked when they found out that, utilizing these simple skills, their child opened up and talked intimately to them for the first time. Children express shock and excitement when a parent actually *listens* to them without blocking communication. Strong feelings of warmth and attachment are generated. Need for drugs disappears in the excitement and "high" of a re-discovered relationship.

Phase three of the P.E.T. program teaches parents how to talk so that the kids will listen. It teaches a parent how to influence his child to modify behavior that is interfering with the needs of the parent; but it teaches a method of confrontation that doesn't "turn the other person off." P.E.T. instructs parent in sending congruent messages that accurately reflect inner feelings. It teaches self-disclosure and transparency which has been demonstrated to be most effective in accurate communication. In this phase a parent may develop self-disclosing behavior that has been experimentally validated by Sidney Jourard at Florida State University. Parents who take the risk of self-disclosure often report reactions of unexpected and sometimes unprecedented reciprocal self-disclosure on the part of their child, generating warmth and closeness which they had never experienced together before. However, it takes some skill to disclose accurately what is going on at a deeper level of awareness and to present it to another person in a non-judgemental or non-destructive way. P.E.T. gives the parent a clear structure upon which he can build his "I-message" in such a way as to keep the locus of the responsibility with the parent who actually owns the problem.

Phase four of the P.E.T. program is based upon a very critical principle. It assumes that, even though the physical and psychological size of the parent and the child is highly variable, the *needs* of both parent and child are *equally* legitimate. This critical assumption is most often overlooked in child-rearing practices, and much psychic pain, resentment and confusion is produced when either party's needs are not being met in the relationship. In fact, when needs are not being met in a mutually acceptable way, *there is no relationship*, and the person involved must seek to meet his needs somewhere else. When a child finds that he can no longer meet his needs in a relationship with adults, he will either withdraw into schizophrenia (the so-called adolescent disease) or he will turn to the peer group. In order to meet his needs for belongingness, self-esteem, security, reciprocal intimacy, etc., in the peer culture, he *must* adopt the norms of that culture. That is our crisis, because the enormous financial interests behind the drug abuse phenomena have managed to make drug use the norm for the adolescent subculture — an overwhelmingly powerful influence in the lives of adolescents.

Needs do not get met generally because there is a conflict between parent and child. The conflicts occur every day in many forms. For example, if my foster-daughter has a strong need to go to school wearing a thin, flimsy coat because it is fashionable and I have a strong need to avoid having to treat her for a cold or frostbite, we have a conflict in needs. Both of our needs are equally legitimate.

I have three choices. I can resort to a win-lose approach in which I utilize my power and authority to force her to wear a heavier coat. Result! I win, she loses and resents not getting *her* need met. Or I can become the permissive "have-it-*your*-way" parent, in which case she wins and I lose and resent her because my need did not get met. With either approach we are jeopardizing the relationship with unmet needs.

P.E.T. teaches a third, no-lose method of solving need conflicts. Utilizing the principles of management which have been effective in industrial psychology, P.E.T. teaches parents a method of problem solving or conflict resolution which not only arrives at an equitable, need-gratifying solution, but also a method which gives a child an opportunity to take *responsibility* for meeting his own needs. Thus a child may learn the vital lessons of personal responsibility at a very early age.

For most parents taking the P.E.T. course, there is a vital secondary benefit, especially where both parents are involved. The skills acquired in the course vitally contribute to the strength of the marriage. In fact, the principles and skills of P.E.T. can be applied in almost *any* relationship, whether it be parent-child, husband-wife, employer-employee or teacher-student.

It must be noted that P.E.T. is designed as a *preventive* program, offering help to parents before

maladaptive behavior develops and the relationship deteriorates. Its efficacy upon established pathological conditions is variable. Carl Rogers admitted that the democratic, client-centered approach was not effective with outpatient sociopathic syndromes because the child had already developed a manipulative life style and could easily manipulate the course of client-centered therapy. My own experience has been that a combination of P.E.T. methodology and a therapeutically-sensitive directive encounter approach is most efficacious in cases in which the sociopathic behavioral patterns are already well established and where drug dependency is not a factor.

The strength of P.E.T. lies in the fact that it is a low-cost, educational rather than "therapeutic" approach which deals with parents, not as patients with psycho-pathology, but as persons who desire to do a good job as parents but lack the appropriate skills and knowledge required. Thus it avoids the stigma of going to a psychologist or psychiatrist and the fear of "psychological undressing" or open confrontations frequently associated with sensitivity or encounter groups. On the contrary, P.E.T. actually teaches parents how they can become effective "therapeutic agents" in their own homes, utilizing the same skills as the professional therapist or industrial psychologist might use in his own practice.

Research upon the effectiveness of P.E.T. courses has demonstrated that P.E.T. graduates become more democratic in their attitudes towards their families, more accepting of their children, more tolerant of conflict, more confident in their ability as parents. Children, on the other hand, showed fewer behavior disorders, less hostile detachment, and significant increases in self-esteem after their parents had taken the course.

The problem of drug abuse cannot be currently alleviated by P.E.T. methods. However, the program offers a strong element of hope for future control, not only of drug abuse, but also many other behavioral disorders that have their roots in the deteriorated communicative relationship between parents and children or teachers and students. Rearing and educating children are extremely difficult tasks, and we would not undertake any other task so important without first becoming thoroughly trained. P.E.T. is the first systematic attempt to fill the void and develop the vital skills necessary to raise healthy children and prevent psycho-social disorders.

REFERENCES

1. Dr. Gordon also has described his principles in a book *Parent Effectiveness Training — The No-Lose Program For Raising Responsible Children.* Peter H. Wyden, Inc., New York, 1970.

Alcohol in Alaska

During the fiscal year July 1, 1970 - June 30, 1971 Alaskans imported:

1,024,467 gallons of distilled spirits
5,031,625 gallons of wine
5,735,709 gallons of beer

The average yearly consumption for each adult over 18 years figures out to be:

distilled spirits - 6 gallons per year
wine 30 gallons per year
beer 34 gallons per year

(Someone is drinking my share! — ed.)

AURORA DENTATUS

Midwinter Meeting
Juneau
January 29, 1972

All members are urged to attend. Very serious and urgent matters are before us which require action by the society. The first business session has been rescheduled to 3 P.M. Saturday, 29 January. Please note this change.

Continuing Dental Education Course
University of Washington
31 January, 1 February

Following the above meeting, Dr. D. F. Haselnus, past president. Academy of General Dentistry, will present a course on "Functional Occlusion, Periodontics, The Solution to Successful Dentistry". Here is an outstanding clinician with a valuable presentation for us, it is another must.

ANCHORAGE — Dr. James Sher

HAPPINESS IS A HEALTHY MOUTH

The Alaska Dental Association points out that "Happiness is a Healthy Mouth", especially during Children's Dental Health Week, February 6 - 12.

This is a local-state-national effort by dentists and their auxiliary personnel to focus attention on the importance of good dental health all year long. Anchorage dentists and dental hygienists are emphasizing that prevention is the only possible solution to this country's dental health problem, and a preventive program should start with children.

This year special credit should be given to the Women's Auxiliary members who are coordinating a poster contest with Junior High School Art Teachers. Based on this year's theme "Happiness is a Healthy Mouth". Student posters will be exhibited in The Mall in Anchorage.

Local dentists and hygienists have exhibited their willingness to be of service to the Anchorage community by appearing before school children, talking to PTA groups and appearing on local television stations. They promote the basic themes:

1. Brush after eating.
2. Use of dental floss between the teeth.
3. Cut down on carbohydrates which are a major cause of tooth decay.
4. Use of flouride as a preventive means.
5. Regular dental check-ups.

Mayor George Sullivan of Anchorage stated as he proclaimed Children's Dental Health week in the city: "Since the future is, to a large measure, dependent on the good health of our children and youth, the citizens of tomorrow; and good health, physical and mental, can be achieved through good health habits learned early, I urge that all citizens and all community organizations join in the observance of Children's Dental Health Week."

KETCHIKAN — Dr. Aubrey Stephens

Lots of snow here, yet Jim Van's holiday included the California variety for skiing.

The latest R M P clinician, a Dermatologist, presented good material of interest to Physician and Dentist.

KENAI — Dr. Chuck Bailie

Miss Tracy Ann arrived at the Bailie house to make an especially Happy Holiday season.

The last meeting of the Kenai-Kodiak Soc. was held across Katemak Bay in December. Good fellowship — good lectures with a duck bonus.

1972 — Let's Make It A Good Year

This is the era of the "Task Force", the "Advisory Council", the "Health Program". Some of our profession are members of these groups which propose to control our destiny under the well-intended guise of improving the nation's dental health. The literature and the general press contain almost daily articles on the subject. Some truth is contained in them, but also much non-specific conjecture and conclusions without basis appears. Many believe the nationalized program in England is good! There must not be enough of us around to remember the exodus of practitioners from Britain, the period of 15 years or so since a new hospital was built, the great

increase in patient load per dentist, the unbelievable number of dental extractions and dental prostheses, and the phenominal cost to the taxpayer for this "Health Care".

Wherever we turn, we are being pressured to change the delivery of dental care. From Washington, D. C. to the bush village this phrase is repeated over and over in all sorts of ways by all sorts of people — lay and professional.

Definitions are seldom included and more seldom accurate. What exactly is meant by a change in the delivery of dental care? Is it emphasis on preventive dentistry, is it curriculum changes in dental schools, is it socialization?

This is the era of repetitive, but similar, statements. Today's television advertising is a good example of the technique. The most obnoxious ones are repeated until they are retained by the audience, and products are sold.

Whether by bureaucrats, representatives of the profession or by the advisory lay groups, statements regarding changes in the delivery of dental care should be answered promptly and with factual basis. Change is necessary for the furthering of standards, but dentists have to make the changes of their own volition. The fact that dentistry in the USA is the world's best is testimony to this volition.

One particularly volatile subject being discussed is relative to group practice versus solo practice; sometimes it comes labeled HMO. Many assume this is good for the patient and the dentist; is it? What studies can be quoted, and if so what are the full circumstances? The USPHS experiment in Louisville might be difficult to repeat in civilian practice, furthermore statistics can be used many ways when necessary.

Are group practice advocates admitting that the graduates of our dental schools are so narrowly oriented that it takes a group to do what one dentist should be able to do? Is our dental education program producing a product that has difficulty solving the average dental problem? Has income productivity influenced dental educators to the point of turning out too many sophisticated products? The specialty board men have a rightful place in the profession. Thank God they are available and as superior as they are, for US dentistry could not maintain its high standards without them.

Solo practice is a basic concept of modern dentistry. Will it be modern if basics are altered or destroyed? 1972 holds great promise. Let us progress and lead rather than be led or misled.

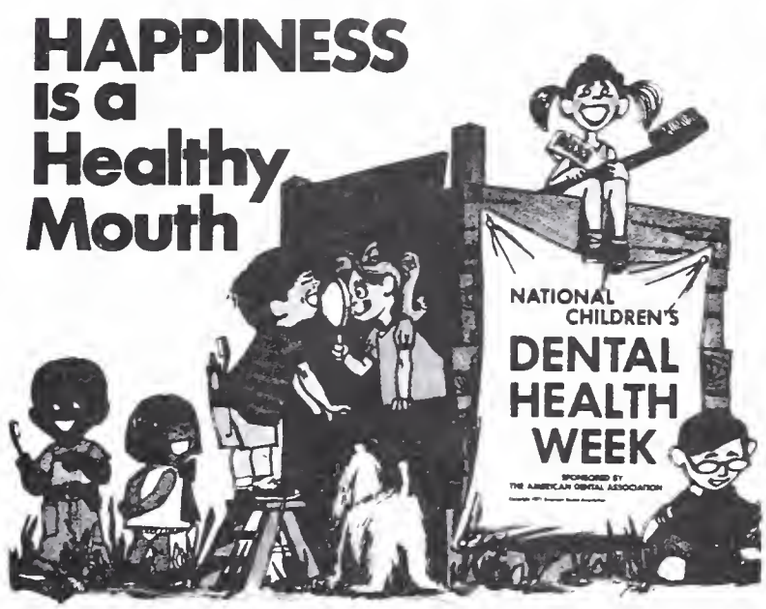
— Ed.

A TOAST FOR THE NEW YEAR . . . .

Thomas J. Murdock, D.D.S.

Tom is the Editor of FLIGHT WATCH, the publication of The Flying Dentists Association. They need new members, and if you are interested, write him at 312 South Midwest Blvd., Midwest City, Okla. 73110.

Here is to three major sins of man that hopefully you are above — stealing, lying, and drinking. However — if you must steal, steal away from evil companions. If you must lie, lie to protect the virtue of a woman. And if you must drink, drink with me!



MUKTUK MORSELS

27th Annual Meeting
Alaska State Medical Association
June 1, 2, 3, 1972
Anchorage-Westward Hotel

The joint House and Senate legislative hearing is scheduled in Juneau for February 3, 2 P.M. Senator Lowell Thomas and Representative Genie Chance have agreed to their Health, Education and Welfare Committees meeting in joint session to hear testimony by the ASMA and others regarding new and pending Alaska legislation.

The Alaska State Medical Association Council met January 8, 1972, in Anchorage. Private physicians and health agency representatives from throughout Alaska attended and discussed topics of importance to the medical profession and all Alaskans:

1. Alaska Native Land Claims and its effect on Alaska Native health services.
2. Alaska State Board of Medical Examiners recent activities.
3. Restructuring of the AMA.
4. State legislation.
5. Health manpower
6. A new view of health education.
7. Health maintenance organization and peer review.
8. Medico-Legal problems.
9. State mental health programs.
10. New health facilities licensure rules and regulations.

The minutes of this meeting are available at the ASMA office.

ANCHORAGE

Doctor MILDRED MCMURTRY has recently begun general practice in association with Doctor MARCELL JACKSON. Doctor McMurtry recently practiced in association with Doctor ROYCE MORGAN.

Doctor GLENN CRAWFORD recently was elected President of the Anchorage Medical Society. Doctor DON ROGERS was elected President-Elect and Doctor MICHAEL CUSACK Secretary-Treasurer.

The Anchorage Comprehensive Health Planning Board held a "welcome to Alaska" party for its new Executive Director, S. Shivinanda, at the home of Doctor ROBERT B. WILKINS.

Doctor JERRY LITTLE will have a "MEDEX" practicing in association with him at the Alaska Clinic in March of 1972.

It took over six years for Gwynneth Wilson, wife of Dr. Rodman Wilson, to establish a residence for girls in Anchorage as chairman of a committee of Church Women United. Aquarius House opened in August 1971 in a house at 1633 Wickersham Drive purchased through donations to the church group. Alaska Children's Services manages the home, which currently houses house-parents Ron and Patty Ohlson and six teen-aged girls, mostly native, several of whom have never had an adequate home.

FAIRBANKS

The Fairbanks Medical and Surgical Clinic and the Tanana Clinic will each have two "MEDEX" working in their clinics in March of 1972. Doctor JAMES LUNDQUIST and Doctor ROBERT ROTH from the Tanana Clinic will each have one. Doctors JOE RIBAR and CHARLES TOWNSEND from the Fairbanks Medical and Surgical Clinic will also each have one.

KENAI PENINSULA

Doctor JOHN NOYES of Seward was recently elected President of the Kenai Peninsula Medical Society. Doctor PETER HANSEN is the Secretary-Treasurer and Doctor PAUL ISAAK is the ASMA Councilor.

Doctor PETER HANSEN will have a "MEDEX" practicing in association with him starting in March 972.

CORDOVA

Doctor GAYLE SACRY left Cordova December 15 to work on Boards in Family Medicine then will move to Montana. Doctor ART TILGNER, recently from Colorado, has taken over his practice.

NOME

A "MEDEX" will be practicing with Doctor THOMAS SIMS and the Maynard McDougall starting in March 1972.

JUNEAU

Doctor GARY HEDGES was recently elected the President of the Juneau Medical Society and will also serve as the ASMA Councilor.

The Alaska Advisory Committee of the Washington/Alaska Regional Medical Program will meet in Juneau on February 4.

The Alaska State Comprehensive Health Planning Council will meet in Juneau February 25, 26 and 27 at the Baranof Hotel.

The Alaska State Hospital Association will have its mid-year meeting in Juneau February 22, 23 and 24.

The Alaska State Mental Health Association will meet in Juneau on February 25 and 26.

KETCHIKAN

Doctor ARTHUR WILSON, JR. has returned to his internal medicine practice in association with his father Doctor ARTHUR WILSON, SR., and brother, Doctor JAMES WILSON.

A Heroin Withdrawal Program . . . .

(Continued from page 32)

c) There is need for a day center or similar facility which is open long hours so they can have a place to go off the street. Such a facility might be run in combination with a place like Anchorage's Open Door Clinic. There is also need for a half-way house living situation for many people.

d) Training and use of ex-addicts to help in treatment of addicts is extremely important in the overall program.

6) Education of community leaders and the community as to the realities of heroin addiction is crucial. Such education should cover medical, emotional and social areas giving realistic facts, as they become available through continued research efforts such as this present effort.

7) Perhaps the most important fact of all is that the treatment of addiction is not a hopeless endeavor. For those involved with heroin addicts find a sense of extreme distress and a great deal of positive human emotion. One also finds an exposure to the senseless waste of the crime and punishment approach to problems of human misery. As with most governmental approaches, more has been spent by far on perpetuating the problems than in attempting to solve them.

NOTES

1. Due to repeated requests for withdrawal by addicts the Clinic staff has discussed offering a withdrawal program again to an individual three months after he has completed his previous withdrawal. This is in line with programs in other states which recognize a large number of repeaters in any program. This would also be available to those people not eligible for a methadone maintenance program. We will entertain initiating this program once we can clarify if state or local governmental funds will become available to the Clinic on a regular basis.

2. It seems paradoxical that Alaska is again sending its patients to an Oregon hospital. It would be a much improved program if patients could be treated in Alaska. Perhaps negotiations can be undertaken with the Alaska Psychiatric Institute to serve as a contract inpatient service for NARA. We have never had more than four to six patients in the program at anv one time.

3. The $chi^2 = 3.91$, $P < .05$ phi = .21 which means that the relationship between employment and withdrawal could not occur more than five times in one hundred and is thus probably not a random relationship. Correlation of the variables suggests that while the events are related, the strength of the relationship is quite small.

ALASKA MEDICINE

Volume 14, Number 2, April 1972

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Precautions: In the elderly and debilitated, and in children over six, limit to smallest effective dosage (initially 10 mg or less per day) to preclude ataxia or oversedation, increasing gradually as needed and tolerated. Not recommended in children under six. Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider individual pharmacologic effects, particularly in use of potentiating drugs such as MAO inhibitors and phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions (e.g., excitement, stimulation and acute rage) have been reported in psychiatric patients and hyperactive aggressive children. Employ usual precautions in treatment of anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation have been reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship has not been established clinically.
Adverse Reactions: Drowsiness, ataxia and confusion may occur, especially in the elderly and debilitated. These are reversible in most instances by proper dosage adjustment, but are also occasionally observed at the lower dosage ranges. In a few instances syncope has been reported. Also encountered are isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent and generally controlled with dosage reduction; changes in EEG patterns (low-voltage fast activity) may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice and hepatic dysfunction have been reported occasionally, making periodic blood counts and liver function tests advisable during protracted therapy.
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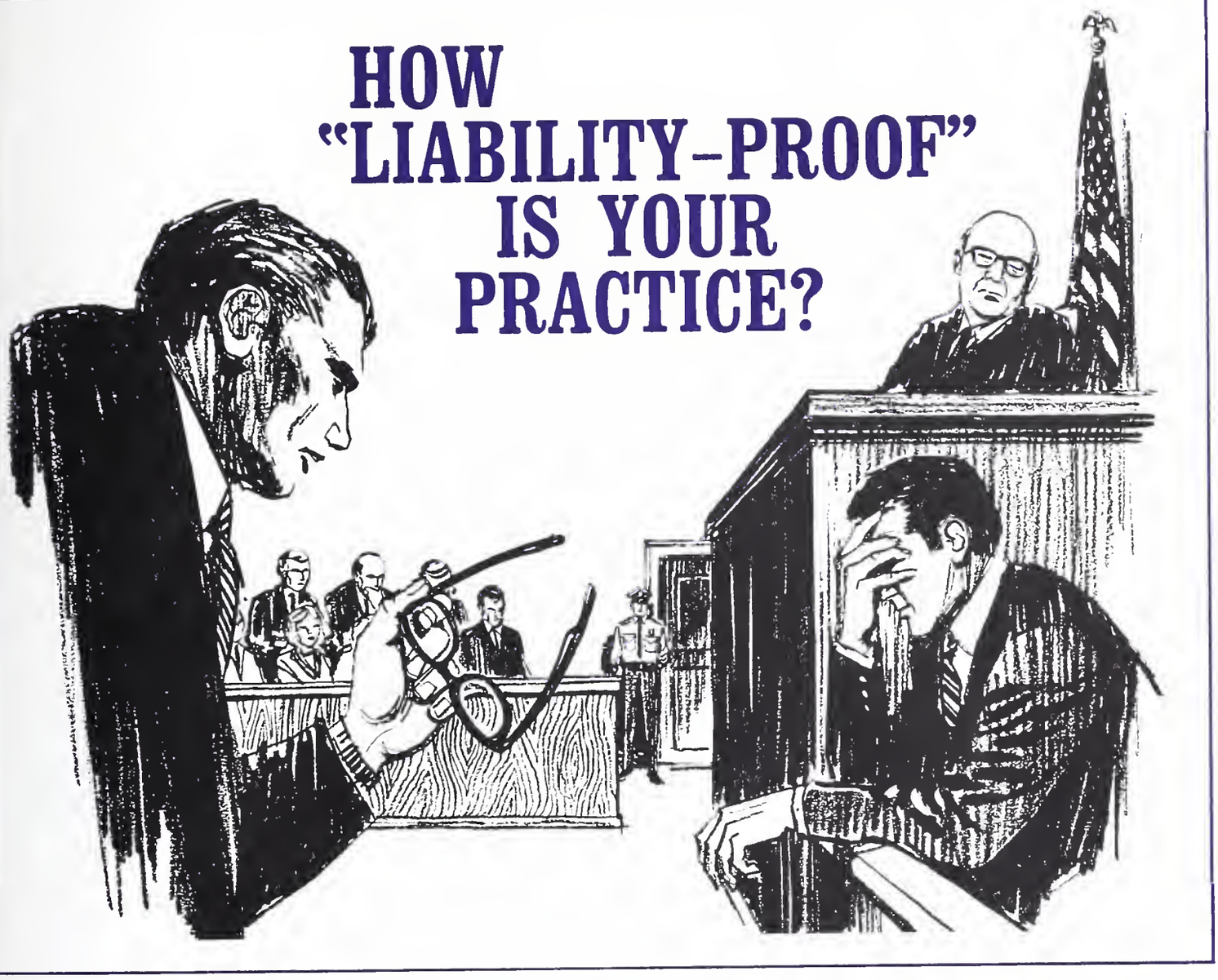

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ALASKA MEDICINE

Official Journal of the Alaska State Medical Association
Official Journal of the Alaska Dental Society

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APPLICATION TO MAIL AT SECOND CLASS POSTAGE RATES IS PENDING AT ANCHORAGE, ALASKA

Volume 14 | **April 1972** | **Number 2**

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ALASKA MEDICINE is the quarterly journal of the Alaska State Medical Association and the Alaska Dental Society: Alaska Medicine, 1135 Eighth Avenue, Suite 1, Anchorage, Alaska 99501. The second quarter issue was printed April 1972 by Ken Wray's Print Shop, Inc., Anchorage.

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ABOUT THE COVER

"Alaskan Medical Saga"
4' x 8' mural, oil painting on masonite
by Fred Machentanz

This mural painting represents through a montage of people, places, time and things, the career of Dr. Milo Fritz in his travels and work among the native people of Alaska.

At the top of the mural are shown the three usual types of travel in the "bush"; from left to right by umiak, plane and dog team. Coming from the plane towards a group of waiting Eskimos in top center is Dr. Fritz and his wife, Betsy who serves as his nurse on these trips. She is carrying her nurses' bag and he his identifying outsized carrying case for instruments.

In the montage below them can be seen some of the natives he has treated including Jimmie Otyohok from St. Lawrence Island on the left and Jimmy Huntington, the original "Huslia Hustler" on the right. Just to the right of Huntington, Dr. Fritz is shown doing microsurgery. The nurse on far left, center and right is wife Betsy engrossed in some of her many duties. Fitting glasses on the left is John Spahn who has often accompanied Dr. Fritz on these trips. At the bottom of the blue montage, Dr. Fritz performs as an eye, ear, nose and throat surgeon.

Below the sky section of the montage are shown the areas of Alaska served by Dr. Fritz. On the left is southeastern Alaska with its familiar mountains, craggy trees on rocks, fish trolling boats and the Mendenhall Glacier near Juneau. Next is Pioneer peak, landmark in Matanuska Valley in southcentral Alaska and after that, Mt. McKinley, 20,300 feet high, tallest mountain in North America to represent Interior Alaska. The cone-shaped volcano, Shishaldin represents the Aleutians and to the right of that "Nanook" (polar bear) on pressure ice overlooking a whaling camp below symbolizing Arctic Alaska.

Representing Dr. Fritz' unshakable belief in the Christian ethic is the Episcopal Mission at Allakaket. Shown with the mission, which is north of the "Circle", is the familiar fish wheel on the left and the salmon drying on a rack.

To complete the cycle in this Odyssey, the times of year are indicated by spring on the left, then summer with its green birch leaves gradually turning to fall gold and finally on the far right, winter in the Arctic.

The project in all took five years since its commissioning and is painted on masonite with a prepared white ground. The whole painting was started in blue and white. Then, additional color was added to the base landscape by a series of six or eight, each one drying before another is added. This is much the same technique as that of the Old Masters and Renaissance artists such as Rembrandt, Titian and Vermeer.

LETTERS TO THE EDITOR

SUICIDE PREVENTION IN ALASKA

Dear Sir,

There are many facts and figures describing the importance of suicide as a cause of death in the United States today. However, the singular fact that it is a leading cause of death in our young people, is sufficient evidence for considerable study and effort toward the prevention of the suicidal act. [1]

The model of prevention initiated by the Suicide Prevention Center of Los Angeles over ten years ago has proliferated throughout the United States, especially in demonstrating the use of the crisis telephone answering service. The telephone, in spite of the fact that it has been, and we assume will continue to be, an instrument of the devil as far as many family physicians are concerned, is still an instrument, when properly used, that permits the average citizen to enter into care any time in twenty-four hours with the dignity that should be his. It is this dignity of introduction into helpful circles that makes the suicide telephone answering service a unique contribution on the American scene.

Provision of emergency telephone services has long been a necessary part of the mental health center movement, and the National Institute of Mental Health has suggested the following guidelines:

1. Telephone coverage 24 hours a day, 7 days a week, with a well publicized number available to the public and community caretakers.
2. Telephone service manned by trained personnel.
3. Trained mental health professionals available to back up the telephone operator.
4. The telephone service shall have direct access to all center services and to other care services in the community.
5. The emergency telephone operator shall, without exception, record all calls as well as the action taken.
6. All logs will be transmitted daily to the emergency service for review and necessary follow-up.
7. A current directory of all mental health and other care services in the community shall be at the hand of the mental health worker.
8. The number of the emergency service should be made widely known throughout the entire community.

Without a mental health center to provide the above, and with a dearth of professionals available to the public, some Alaskan communities have established independent telephone services with a variety of schedules, organizations and techniques.

The Anchorage Suicide Prevention and Crisis Center was the first to open in Alaska under the sponsorship of the Anchorage Mental Health Association which continues to be the sponsoring agency. This inaugural service was started by a committee of professionals and members of the Anchorage Mental Health Association who gathered weekly for approximately five months in order to determine basic policies regarding the Center. Several committees were appointed to contact the telephone company, the police, the hospitals, to determine a need for the Center, and to do research on other centers throughout the United States. These groups developed a training session with the goal of helping each of the volunteers to learn the art of telephone therapy. Essentially, each volunteer is expected to be able to establish a relationship on the telephone with the caller, to assess the immediate danger and crisis that is presenting itself, to plan the next move with the caller and, finally, to follow up the next day to be certain that the caller has had assistance in his crisis and has been referred to the proper resources.

The Anchorage Suicide Prevention Center opened on September 8, 1970, followed shortly by the Fairbanks Crisis Line, Inc., which opened on September 15, 1970. Since these centers have opened, other telephone-type services have been started and we now have a teenage center, established through the Anchorage Community YMCA, known as the Dial-A-Friend Center. Also, an active program is being started in Nome in response to a series of suicides of frightening proportions in the winter of 1972.

Several very important aspects in the manner of developing prevention centers have been demonstrated. First of all, it is necessary to have a backup service of professionals on call to support the telephone operators as they manage crises. In Anchorage, which has a twenty-four hour, seven day a week service, manned by two people in four shifts, the person handling the crisis can continue with the caller while the second telephone operator may call the backup person for consultation or, perhaps, the ambulance service, or any other emergency services necessary to assist. There were sufficient calls to the Anchorage Center, that even two telephones had to be supplemented with a third telephone; two for the actual service of the Prevention Center, and one for personal calls of the volunteers.

The backup professionals have also organized and meet monthly to assist with the Center's operation and to offer helpful professional consultation and supervision. Without these backup people, we are certain the Center would not have the security necessary to carry out its functions properly. These volunteers in Alaska are dedicated individuals, both professional and non-professional, and have contributed much to the health of their communities as a result of their center activity.

Finally, each group has developed contact with many of the helping agencies within the area. They not only know what services are provided by each agency, but they also have personal contact with the individuals at each agency. They have compiled the most complete up-to-date reference manual for contacting the service specifically needed.

In order to give an example of the kind of service being provided by the telephone operators, we received permission from the Anchorage Suicide Prevention Center to publish some of their statistics. When the Center opened in September of 1970, it received 51 phone calls during that month. This jumped to 167 phone calls in October, and by March, 1971, had reached a high of 297 phone calls. In total, the Center received 1,335 phone calls in its first seven months of operation. More recent statistics indicate the following:

DECEMBER 1971

Type of Call	Number of Calls
Alcohol	20
Drugs	12
Emotional	8
Financial	4
Suicide	20
Questionable	6
Crank	2
Information	54
Talk	67
Family	15
Other	5
Total Calls	213

Number of calls, male	93
Number of calls, female	120
Number of calls in daylight hours	79
Number of calls in night hours	134

Definition of some of the above terms is, perhaps, necessary to understand the significance of the table. Alcohol and drug type calls are, of course, self-explanatory. However, the emotional and financial calls may need some explanation. Frequently, acute emotional upset or simply being down and out without a place to go, becomes a serious problem. The Suicide Prevention Center has worked out a method of handling these particular problems. The questionable calls are those calls that are not able to be identified and one wonders about the seriousness of the caller. The crank calls are self-explanatory. "Talk" calls, which number 67, include people who get a great deal of emotional comfort from conversation with a contact via telephone. The operators, who remain entirely anonymous, have established many therapeutic relationships in this way. Some of the callers are repeat callers and will ask for a certain operator to continue their "telephone therapy". Repeated discussion of problems, release of emotional tension, and the complete freedom, due to the anonymity of the relationship, lead to an exposure of problems for the serious consideration on the part of the volunteer operator that results in positive psychotherapeutic intervention. These statistics could be duplicated each month of operation and demonstrate the type of important service the Suicide Prevention Centers are accomplishing.

The problems of the Center are, essentially, those of needing to constantly train volunteers to man the phone service. This is accomplished by a cadre of the experienced volunteers that maintain the service, and who can provide the training for the new telephone operators. Many of the volunteers, through practice and constant study, have become expert telephone therapists over the past several months. The need to know their limits in their roles, the need to remain entirely anonymous, the need to avoid any face to face contact with the help-seekers is stressed in the training programs, and has held us in good stead.

The Anchorage Suicide Prevention and Crisis Center provided training for the YMCA youth when they organized for their teenage telephone service, while the Fairbanks Crisis Line, Inc., is now providing training for the service being established in Nome. Hopefully, these dedicated people will somehow continue to not only provide service for the prevention of suicide, but will also continue to assist other communities in suicide prevention throughout Alaska if called upon to do so.

Sincerely yours,

Lois Pilifant
Executive Director
Alaska Mental Health Association

Carl D. Koutsky, M.D.
Superintendent
Alaska Psychiatric Institute

REFERENCES

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2. *Ten Years of Suicide Prevention - Past and Future,* Norman L. Farberow, Ph.D., Bulletin of Suicidology, National Institute of Mental Health, No. 6 - Spring, 1970

3. *Criteria for Defining Community Mental Health Centers Emergency Services,* pp. 5-6, Bulletin of Suicidology, National Institute of Mental Health, No. 8 - Fall, 1971.

"THE CRISIS IN HEALTH"

Dear Sir:

Dr. Robert Whaley's presentation, Planning for National Health Care Delivery, presumably reflects the thinking of the Legislative Committee.

One hopes that, while firmly stating that the "crisis in health" is a gross exaggeration, the committee has not been stampeded by national propaganda and pressure into the manifest contradiction of at the same time stumping for a major increase in the production of physicians and their assistants. Laid face-to-face the two propositions, if true on the one hand and implemented on the other, can lead only to physician excess and the sociological consequences which must inevitably follow.

Instead of blindly following the piper's tune that more physicians will lead to better health care and health care delivery, it might be well to examine the alternative effects of physician overpopulation: easy political manipulation, economic privation, excessive competition for the health dollar, and reluctant consultant referral, amongst others.

Sincerely,
Winthrop Fish, M.D.

CARDIAC CATHETERIZATION LABORATORY OPENS

Dear Sir,

On January 1, 1972, Providence Hospital opened a new diagnostic center. The Cardiac Catheterization Laboratory was initiated and is being used conjointly by the radiologists and cardiologists. The newly acquired equipment enables personnel to perform a number of specialized procedures which were not attainable prior to this time. Some of these procedures include right heart catheterizations, left (transfemoral and transeptal) heart catheterizations with cardiac output determinations and coronary angiography. Newly acquired equipment allows monitoring and recording of intra-cardiac events from which chamber pressures, valve pressure gradients and valve areas can be determined. Coronary angiography is accomplished using Judkins' transfemoral technique, utilizing both cine-angiography and selective cut filming. Angiographic examination of the entire cardiac system is now available.

Further information concerning this unit with more detailed explanation of techniques and early results will be forthcoming in future issues of ALASKA MEDICINE.

Any questions regarding scheduling of patients and anticipated studies should be forwarded to the Director of the Unit.

Sincerely yours,

James A. Baldauf, M.D.
Director of the Cardiac Catheterization Unit
Providence Hospital

JEAN LEISTIKOW
1942 -1972

Born and raised on a small farm outside Hartley, Iowa, the daughter of intellectual parents, Jean set her goals high. After graduating at the top of her class in high school and college, she found the University of Iowa a happy and friendly place. As she continued her training at the medical school, Phi Beta Kappa, Alpha Omega Alpha, and honors in almost all clinical courses, were routine for her. Until she met me in her senior year, medicine was her whole life and she had never really planned to marry. However, she gave up a Boston Children's residency for Fresno County and me, then came to Alaska despite her fears of cold and isolation.

Jean could never intentionally hurt anyone, neither would she let anyone hurt one of her "little people". Her patients immediately liked her and were unafraid, as if she was one of their own. She worked tirelessly over any sick child, wouldn't rest until things were better, and was not interested in charging for her services. Hers was the joy of giving and seeing the children get well.

In December, 1971, a three-year-old was brought to her office in a coma. After three days and nights of almost constant effort on the Pediatric Ward, the child came out of coma and Jean came home — exhausted but happy. Three weeks later she became similarly ill, and was soon hospitalized with encephalitis. Although she never completely recovered, she was able to resume part-time work in the ANS out-patient clinic, enjoying several field trips to Kotzebue and Barrow. In July, ANS part-time funding ended, and she joined the Pediatric Clinic at Elmendorf on a half-day basis.

She was shy and introverted except with children and close friends, but those who knew her loved her. Her beauty, brilliance, empathy, and love will always be a unique memory for me. —

David Leistikow.

CARMINE FRANKLIN NICHOLAS, M.D.
1933 - 1972

"Oh! I have slipped the surly bonds of Earth and danced the sky on laughter-silvered wings and done a thousand things you have not dreamed of."

On the afternoon of March 11, 1972, about 15 miles from Chelatna Lake, Carmine Franklin Nicholas, M.D. was killed in the crash of a light plane. A well known General Practioner, in Anchorage since 1967, he was on the staff at Community Hospital and Providence Hospital.

Born at Fort Bragg, North Carolina, October 19, 1933, he grew up in the South. A graduate of Concord High School, he received his BS and MD degrees from the University of North Carolina, the latter in 1961. He interned at Portsmouth Naval Hospital and served as a submarine Medical Officer, also qualifying as a "Hard Hat Diver". After leaving the service in 1966, he practiced a year in Utah before coming to Anchorage in 1967 to practice with the late Calvin Johnson, M.D. In 1968 he moved his practice to the College Medical Center. As a member of the Air National Guard he served as Flight Surgeon and as Surgeon of the Alaska Air Guard. He was a FAA Examiner.

Dr. Nicholas is survived by his wife, Wincel, and five children, Allen, David, Patricia, Christine and Geneva Stephens, his mother, Runetta Lee of Concord, N. C., and two half brothers, William of Anchorage and Buddy Lee of Concord, N.C.

Services in Anchorage were held on March 15, with interment in Manning, South Carolina. Frank left us as he would have wanted; doing what he enjoyed most.

John J. Smith M.D.

Sentinel of the Arctic
Collection of Dr. and Mrs. Arthur N. Wilson.

PRESIDENT'S PAGE

By J. Ray Langdon, M.D.

In the past year, despite the economic problems of the country, and especially Alaska, there has been some progress in other fields, and we in the medical area can feel better about our activities.

In the July, 1971 issue of Alaska Medicine, I listed some priorities for us to be concerned with as they appeared then. It seems appropriate for us to review and see what has happened. Often we may be either too optimistic or pessimistic if we do not review and see where we have been.

First was medical discipline and the need for better legislation. As it turned out, the newly reshuffled Board of Medical Examiners reviewed the existing statutes and decided it had probably more power than had been assumed. Having done so, it has been much more active and effective and is developing clearer policies and procedures. The State Association has attempted to support and back the Board and has made its views known to executive or legislative groups as indicated. The component society grievance machinery has been functioning to some degree although it is important to keep reminding ourselves of the importance of this activity. In Anchorage, the once dormant Grievance Committee has come alive and appears to be developing well.

In a related area, our previously established Third-Party Liaison Committees in Fairbanks and Anchorage are developing a certain expertise in dealing with insurance companies and to a lesser degree with governmental agencies. It is planned to develop a state level group composed of chairmen of local committees to keep activities coordinated. Now that the mechanism is established, the membership must remember to use it, and the third parties must be reminded of its existence.

Second was to take closer looks at public agencies. Obviously this is a monstrous task, and it would be unreasonable to expect results on a short term basis. However, the Mental Health Committee has been actively reviewing the situation of Alaska Psychiatric Institute. The Department of Health and Social Services has been working with us much more closely and openly, and generally, we feel our membership has been ready to cooperate. Our newly activated subcommittee on Occupational Health participated with the Department of Health and Social Services personnel in surveying the Valdez situation. We are participating on a Steering Committee regarding the impact of the Native Land Claims on native health, and, hopefully, can make this into a meaningful start on cooperative effort in planning and delivering health care in the future. Though there has been and will be some resistance to our curiosity, there probably will be less as it is realized that we are genuinely interested and concerned.

Third was to look at the educational system. Once again this is a very large, multifaceted problem, and obviously the Medical Association is not the only one concerned today. But we are finding our Steering Committee on Native Health is inevitably noting and commenting on native education. The boarding-home program statewide is coming under scrutiny, and we have been asked for advice and consultation. In Anchorage, the Medical Society has reactivated a School Health Committee, and the school board, which has one of us as a member, has actively functioning Health, Educaton and Mental Health Committees. In other areas, our Education Committee has worked closely with the WAMI program and observed it carefully. We feel the first effort seemed successful and now are encouraging the University of Washington and our members to work toward enlarging medical education in Alaska. A member of this committee is detailed to work with Allied Health Professions in improving health careers education in the high schools, where it is badly needed. The Committee has worked long and hard with the Health Manpower Corporation in setting up the framework for an area health education system which is still quite nebulous, but, a real challenge. Recently, in response to requests from the institution, I have appointed ASMA representatives to the AMU-UofA consortium on nursing education and to a citizens advisory committee for the University of Alaska, Anchorage.

Thus, it is again found that our interest is well received, and when we look closely, it is also found that we have more knowledge and direct concern than we realized.

Fourth regarded the criminal justice system. We must especially develop more concern for the most neglected area of corrections. We have often acted like the lay public in this area — shaken our heads about crime statistics and condemned the criminals. Really we should be much more helpful in this area, and I believe we have more skills in this field than we let ourselves realize. We are finding interested cooperation from some probation officers, officials of the division, some district attorneys, public defenders, and judges.

The problems of criminal justice are being carefully examined by the judges themselves as well as the Bar Association, but are being

hampered by some noisy, wild-eyed groups who complain about any attempt on rational solutions. We, as physicians, must take care not to seem associated with these apostles of social regression, but turn our efforts to helping those who are trying to reform and improve society.

Fifth was considered the problems of VA and military medicine. This is an area of least progress. The military are uncertain of their future, but, we, as civilians should attempt to care for dependents and military personnel themselves as local military medical establishments are depleted. The VA is again swollen with veterans and bureaucrats and is much in need of better contact with private medicine. If, indeed, the VA develops more contract and fee-for-service medical care, we must try to incorporate such care into our practices with an effort to integrate and upgrade care for veterans as well as natives and other groups who we have treated differently.

Among other items we have made strides toward decriminalizing marijuana and in the process have learned much about the really serious problems of heroin addiction and drug abuse. This has caused some complaints, but gradually the true import of what is involved is being understood. Eventually, I believe the Medical Association will be hailed as having been a leader in the change of attitudes. There is a long way to go in the attempts to treat the multifaceted problem of opiate addiction.

Thus we can say there have been some accomplishments, some improvements and considerable cooperation and involvement by our membership. You will note that much of the accomplishment has been demonstration that agencies are willing to talk and work with us and that other areas which we did not regard as our business welcome our assistance. Having demonstrated this, it is up to us to follow through and become constant, involved participants in social change and progress. We have a long-standing, though only partly deserved reputation as a stand-pat or even reactionary organization, and it will take several years of activism to cement a change in this reputation.

So, I wish to thank all of you who have been helpful in the affairs of the organization — and the numbers are legion — and to exhort you to continue improving and adding new programs. May we keep this "the farthest out Medical Association" of all.

Mt. Blackburn, Sovereign of the Wrangells
Collection of Mr. Robert Atwood

27th ANNUAL MEETING
ALASKA STATE MEDICAL ASSOCIATION
JUNE 1, 2, 3, 1972
ANCHORAGE-WESTWARD HOTEL

MUKTUK MORSELS

By Bob Ogden

The Alaska State Medical Association, Alaska Nurses Association, and the American Association of Medical Assistants - the Alaska Society, are planning their 1972 annual conventions together and in conjuction with interim meetings of the Alaska Hospital Association, and Alaska Pharmaceutical Association. The conventions and interim meetings of these organizations will be held together and referred to as the 1st Alaska Health Congress. The Congress will be held in Anchorage, Alaska, June 1, 2, and 3, at the Anchorage Westward Hotel. A tentative program of the ASMA's portion of the Congress is listed as follows. Hotel reservation forms will be sent to all physicians in the very near future.

PLAN NOW TO ATTEND!

JUNE 1, 1972

The first day of the Alaska Health Congress will be a symposium for all health organizations, under the topic "Future Medical Systems". The morning portion of the first day will be didactic presentations by the following speakers:

Mr. Arthur Hess, Deputy Commissioner, Social Security Administration.

Monte K. DuVal, M.D., Assistant Secretary for Health and Scientific Affairs, Department of Health, Education and Welfare.

Tom Answorth, M.D., Executive Director, American Hospital Association.

Hildegarde Peplau, Ph.D., President, American Nurses Association.

Mr. Boyd Thompson, Executive Director, American Association for Foundations for Medical Care.

The Medicine and Religion Committee will have a luncheon meeting.

In the afternoon, tentative arrangements have been made for Lawrence Weed, M.D., Professor of Medicine, University of Vermont, to present via satellite from Bethesda, Maryland, a discussion of "Problem Oriented Medical Records".

Also in the afternoon, each of the above speakers will be assigned to a discussion group.

At 3:30 p.m., the first day, a panel discussion on "Future Medical Systems for Alaska" will be moderated by Commissioner Frederick McGinnis, Alaska Department of Health and Social Services.

Panel members will include Arthur Hess, Monte DuVal, M.D., Tom Answorth, M.D., Hildegarde Peplau, Ph.D. and a representative of health insurance companies.

On the evening of the first day, there will be an informal social function at Mt. Alyeska Ski Resort for all participants.

JUNE 2, 1972

The Alaska State Medical Association Convention will continue with all day specialty sections as follows:

Internal Medicine

Topic	Speaker
Identification of the Patient with Renal Diseases	Thomas C. Wood, M.D., Anchorage
Pathophysiology of Glomerular Nephritis	John Selden, M.D., Anchorage
Topic Unknown	David Price, M.D. Associate Director, Dept. of Nuclear Medicine Univ. of Calif. in San Francisco
Hemoglobin S	Louis W. Nauman, Ph.D. Alaska Medical Laboratories
Chronic Renal Failure	John Selden, M.D.
Medicine and Chronic Renal Failure	Thomas C. Wood, M.D.
Topic Unknown	David Price, M.D.
Panel Discussion	Richard Witt, M.D., Anchorage, moderator David Price, M.D. John Selden, M.D. Thomas Wood, M.D.

Pediatric Section

Child Protection - Community Prevention and Management	C. Henry Kempe, M.D. Professor & Chairman Dept. of Pediatrics Univ. of Colorado
Intensive Care and Management of Ill Neonates	R. E. Thornfelt, M.D. Pediatrician in Charge Intensive Care Nursery Portland, Oregon
Childhood Tuberculosis	Alaska Pediatric Academy Speakers
Echinococcus Disease in Alaska	
Bronchiectasis	
Cytomegolic Inclusion Disease	
Informal Question and Answer Sessions	C. Henry Kempe, M.D. R. E. Thornfelt, M.D. J. Kenneth Fleshman, M.D. John Tower, M.D.

Surgical and Psychiatric

Lumps in Kids	H. William Clatworthy, Jr. Director, Dept. of Ped. Surg Ohio State University
Extrahepatic Portal Bed Block	H. William Clatworthy
Topic Unknown	Norman Paul, M.D. Family Therapy Consultant Boston City Hospital

The American Academy of General Practice - Alaska Chapter will hold its annual meeting and luncheon.

At 4:00 p.m., the House of Delegates will have a short meeting to hear:

1) the reading of resolutions,
2) nominations of officers,
3) proposed By-Law changes.

JUNE 3, 1972

The House of Delegates of the ASMA will meet *all day.*

The Alaska Medico-Political Action Committee will hold its annual meeting and luncheon.

There will be a joint banquet of the ASMA, Alaska Nurses Association, American Association of Medical Assistants - Alaska Society, in the Alaska Room of the Anchorage Westward Hotel.

JUNE 4, 1972

9:00 a.m., the ASMA Council will meet to begin the work for their 1972-73 year.

HOMER

PAUL ENEBOE M.D., has taken a one-month leave of absence from his practice to establish a "Pot Shop" at the end of the Homer Spit. Doctor Eneboe assures us the pot referred to is the clay type.

ANCHORAGE

GLENN CRAWFORD M.D., recently returned from a two-month vacation in South America.

DONALD B. ADDINGTON M.D., has relocated his office for the practice of plastic maxillo-facial and reconstructive surgery to Providence Professional Building, 3300 Providence Drive, Suite 205, Anchorage, telephone 277-3558.

HOWARD ROMIG M.D., has recently returned to practice in the Medical-Dental building at 140 East 5th Avenue, Anchorage.

The AMERICAN COLLEGE OF CARDIOLOGISTS will be holding their annual meeting in Anchorage June 21, 22, 1973. Sponsored by the University of Washington Chapter, American College of Cardiologists, the subject is to be Arteriosclerotic Heart Diseases. The meeting will be held at the Anchorage Westward Hotel.

DAVID DIETZ M.D., had a baby boy.

DION ROBERTS M.D., had one too. So did PAUL SAYER M.D.

To keep things balanced,

TRYON WIELAND M.D., adopted a baby girl.

CORDOVA

Doctor ART TILGNER will have a MEDEX, MIKE GROGAN, practicing in association with him in Cordova in April, 1972.

FAIRBANKS

Doctor TOM CARTER, an Internist and member of the Tanana Medical Clinic, has been reported missing on a flight from Fairbanks to Whitehorse. Dr. Carter has been missing for several weeks as we go to press.

JUNEAU

The legislature is still in session, and most of the bills of health importance are not visible due to the legislature's emphasis on pipelines and election year jitters. The ASMA's Legislative Committee meets almost every Saturday morning at 9:00 a.m. at Providence Hospital. If any members of the ASMA are interested in assisting in passage/opposition to legislation, they are encouraged to attend the Legislative Committee meetings.

TRADITIONAL MEDICAL CURES ALONG THE YUKON

By Ginger A. Carroll
Tanana

For centuries the Athabascan Indians along the Yukon river have adopted a pragmatic approach in their traditional medical practices. This approach, however, has been influenced and supplemented by a strong reliance on spiritual intervention. Though regional differences occur, the Athabascans of this region employed two basic types of medicine — herbalism and shamanism.

For the purpose of discussion in this paper, the Yukon River region has been divided into three ethnographical regions (Figure 1). Traditional cures as practiced among the people of each of the three regions will be described, followed by an amplification of shamanistic exploits in each area.

The first group of people, the Chandalar Kutchin, treated cuts and wounds by covering them with a poultice made from boiling the macerated leaves of the anemone. This highly astringent mixture was applied for only a few minutes at a time. Roots of arctic dock were eaten as a cure for colds, as were juniper berries for the relief of chest pains. A concoction made from boiled alder buds was drunk as a cure for venereal disease. [1]

The sweathouse was not used by the Indians along the Chandalar, steaming and sweating being employed only in connection with sickness. The vapor resulting from boiling the leaves of a flowering plant found on mountain tops was believed to alleviate colds and chest pains. Treatment consisted of disrobing, wrapping one's self in a blanket and standing over the steam. [1]

Tattooing was practiced as a cure under certain conditions, most often for a person with "bad legs". The sufferer would have a circle tattooed around his or her ankle to bring strength to the afflicted extremities. Tattooing ink might also be rubbed on a sore leg. At times ink was spread on the deformed face of one who had suffered a paralytic stroke. [2]

Bloodletting was a favorite remedy for many ailments, particularly aches and pains. A small lancet was used, consisting of a triangular point set in the end of a short, wooden handle. An incision was made directly over the afflicted area, snowblindness being treated by an incision over the eyes, kidney pains and backaches by incisions over the kidneys, etc.

In addition to medications and bloodletting, this group also employed certain hygienic practices. Soap was made by boiling birch leaves with grease, but the exact process is not available. After eating, the people picked their teeth with splinters or porcupine quills. When de-lousing, lice would be cracked between the teeth but not eaten. Following defecation the people would clean themselves with a small piece of wood used as a scraper. [1]

In the middle Yukon region spruce trees are abundant. Here the Indians used spruce pitch as the most common medication for cuts and scratches. Anna Barker, a registered nurse of Athabascan heritage, contends that it was not so much the healing properties of the pitch but the fact that it kept the would clean and thus prevented infection during the natural healing process. A cure for boils long used by the Tanana Athabascans was also described by Mrs. Barker. A bottle with a small neck was heated and the top placed over the boil, thus creating a vacuum. The bottle was then turned until the fluid from the boil was drawn out.

Other traditional medical practices included the splinting of broken bones by encasing them in a tubular bark splint. When the bone began to heal, the splint was removed and a binding of pitch covered with cloth or skin was placed over the area. The general indication that healing was almost completed was an itching under the pitch. The pitch was then allowed to wear off, and when it dropped away, the healing was complete. Sore eyes were treated by scratching them with the remains of a dried cyst cut from a caribou which had been attacked by a fly. Tea, which had been introduced into the native culture, provided a cure for upset stomach and diarrhea. The dry leaves were chewed and the juice swallowed. A more recent cure consists of a mixture of flour and water burned in a pan and then swallowed.

The Ten'a of the lower Yukon employed many of the same traditional cures as the people further up the river. They too made extensive use of the spruce trees which also flourished in this region. The sap and resin were spread on cuts and minor burns. The bark was boiled and the resulting liquor used as a remedy for a sore throat. Spruce needles which had boiled all day were consumed to ease stomach pains. Other common remedies for stomach aches included warm berry juice and powdered charcoal mixed with water. Red ochre was applied to extensive burns, while self-induced nasal mucus was spread over small burns. To stop a nosebleed, some of the blood was spread across the face from the nose to the forehead. This act, by

associative magic, was supposed to turn the direction of the flowing blood. Fish eggs served a variety of needs. When eaten they checked coughing, whereas hot eggs were held over the eyes to ease the discomforts of snowblindness. Fish eggs and rhubarb were consumed to relieve constipation. The dorsal fin of a grayling was used to soothe a throbbing toothache. Earache was treated by leaning one's ear over the burning tail of a ground squirrel so that the smoke entered the ear. There may be some professional misgivings about the therapeutic value of the smoke but no doubt the heat from the fire had a soothing effect.

Though traditional remedies often brought relief, spiritual intervention was also important. The Ten'a theory of disease embodied the idea that people became sick because a spirit called the *Giyeg* thought about them — just as though he was setting traps for them. If a person was captured by this spirit and nothing was done to distract him, the victim would die in one or two days.

Despite the fact that a supernatural element was used to explain the reason for disease, the people did in some instances recognize the more tangible causes of disease. They knew that there was danger in eating infected food. Meat was known to keep only three or four days in summer and bad fish was also known to be dangerous.

Stomach upsets were thought to be the result of steam or hot gas in the viscera which could lead to vomiting. Coughs were said to be caused by white stuff in the throat which produced an irritation. This type of cough was distinguishable from the slight nervous cough which some people had from birth, this latter type being attributed to the fact that a person's tonsils were too short. Hiccuping was believed to be caused by food and was transmissible in an unusual fashion. If a person laughed or talked about another who was hiccuping, he was very likely to find himself in the same predicament. The victim took water to stop the hiccups and held his hand over his mouth while closing the nose between the thumb and first finger. Air was cut off for as long as was required. Excessive crying was discouraged since someone who cried a great deal might become ill as a consequence. Trembling resulting from cold or fear was thought to be caused by the heart. [4]

Regardless of its type or origin, sickness was a general concern and was commonly discussed. When a child was ill the parents talked of nothing else. The mother was often so worried that she was unable to eat. [4]

To make young children strong and healthy, they were sometimes fed the flesh of young pups or dog's excrement, mixed with other foods. One father known to fortify his children with this tonic did not prevent several of them from dying prematurely. Parents who lost several young children gave the surviving ones to some childless couple, who by adopting them, saved them from the death to which they were doomed in their own family. [5]

An interesting notion held by the people was that sickness could be contracted from another person by sitting in that person's place, providing that the latter had been ill. This belief perhaps explains the custom that while visiting friends one would squat on the flat part of the feet with knees and buttocks off the ground.

In the home of a sick person the use of any sharp cutting instrument was taboo. Life, being in a precarious situation, might be cut off by the use of a sharp tool in close proximity to an individual. For this reason, during the winter the preparing of shavings to start the next day's fire was always done outdoors, even at -70 degrees. It was even desirable that this task be done by someone not in the patient's family. Likewise, sawing and splitting wood for the house were generally done by a benevolent neighbor so that relatives of the sick person might be spared the anguish of endangering his life. [5]

When traditional medications failed, or in cases of physical injury, the shaman, or medicine man, was summoned. As the role of the shaman differs only very little in all the settlements along the Yukon, a brief general description of his activities is in order. Generally speaking, it was the province of the shaman to assist the men in their food quest, to guard the people against the effects of evil spirits and to restore to health those who had been harmed by evil spirits. It is the latter function which will be amplified in this paper.

When someone was ill or suffered an accident, the shaman was invited to find a cure. The usual treatment was to examine the patient, blow on his hands, and rub him. If the pain was localized, he massaged that area. This procedure would last for only a minute or so after which the shaman would tap his tambourine and sing medicine songs. Payment for his services was essential. Charges were not fixed but agreed upon by the shaman and the patient's family. Remuneration varied according to the distance in the relationship of the shaman to the patient.

The Chandalar Kutchin believed that in addition to physical causes a temporary departure of the spirit was a primary factor in illness. In the latter case a shaman was asked to recapture the spirit. The practice of shamanism among the Chandalar Kutchin had diminished by the 1930's due to the influence of Christianity, but it was not entirely displaced. Four men in Arctic Village were occasionally practicing as shamans and the native deacon had once been an active shaman. Prior to the dominant influence of Christianity a shaman was usually, though not always, a man. Any person

could become a shaman. Around the age of 15, a young man would begin to dream a good deal and upon awakening would sing. In his dreams his spirit traveled extensively and acquired an animal helper called "Yitsotci" (the animal to whom he sleeps). During these times of dreaming and singing the young man lost his appetite and became thin. Experienced shamans were called to diagnose this peculiar malady and ascertain where the spirit had been traveling during the dreams. Several places were mentioned and when the correct one was named the youth would involuntarily jump several feet in the air. Then it was known he would be a future shaman and all his activities were henceforth watched with the closest scrutiny. At the first sign of shamanistic success the new shaman was welcomed by the other shamans as one of them. [1]

Every shaman possessed a medicine bag whose contents symbolized various magical powers; for example, a small ermine skin, a bear claw or dirt resembling wet ashes. Each shaman also employed one of several magical songs. If one appeared unsuitable for the purpose at hand, he tried another. Drums were not used but occasionally rattles, made of caribou hoofs provided accompaniment. When a shaman was unable to effect a cure he would run a spear through his body, sawing back and forth, or shoot himself with a gun. After apparently killing himself, he would regain consciousness and not a scar would be visible. [1]

Among the procedures routinely employed by the shaman was the removal of foreign objects. One of two methods was used. The first consisted of sucking, blowing, or pulling on the object to the accompaniment of appropriate magical songs. The more dramatic treatment was magical surgery with a special wooden knife. Joe Number Six, who claimed to have experienced this unique type of surgery, described the incident:

> When I was a boy I used to be troubled by bad stomach aches and diarrhoea so my father took me to a shaman at the head of the Porcupine river. The shaman made a knife of wood and painted it with charcoal. He thrust this in my belly right under the breastbone and cut down as far as my navel. He took out my windpipe and blew through it before putting it back. He pulled out my intestines and washed them off in a bowl of water. When he put them back, he pressed the wound together and rubbed it until it healed. There is not even a scar there today. I saw him do all this, but I did not feel a thing. After he had finished, the shaman sat down in the back of the tent and said, 'you will get better now. If I die before you do, you may have a touch of your old trouble again.'
>
> I had no more trouble for a long time. Years later when I was camped below Fort Gibbon (Tanana), the trouble suddenly came back. I remembered the shaman's prophecy and felt sure he must be dead. I learned later that he had drowned at just about this time. [1]

Moses Martin, 86, a long time resident of Birch Creek and Fort Yukon related to me the story of a personal friend who had undergone a similar operation. As a youth his friend fell gravely ill and a shaman was asked to cure him. As the boy's family stood around his pallet and watched, the shaman heated a sharp wooden knife until it glowed. Singing some songs, he then cut open the chest and sucked out the "badness". The incision was closed by burning the skin together with pieces of hot metal. The shaman then said that the patient would live to have white hair. Moses often saw the scar on his friend's chest that went from "here to here," he said, running his finger along his sternum. Moses went on to say that his friend, who did have white hair, died just a few years ago.

Alice Moses of Chalkyitsik, a woman in her early forties, stated that bloodletting was another routine procedure of the shaman until quite recently. Blood was allowed to drip from punctures in the lip. If the blood was bright red, the shaman recited some magical words and the person was said to be immune to tuberculosis. however, if the blood was dark in color, tuberculosis was already present and the shaman could do nothing.

Clifford Stevens, 18, of Stevens Village told of rumors that a man of about sixty was a shaman. He was said to sing in a language that no one understands. Mothers warn their children not to "hand around him or laugh at him." Once, when Cliff's mother was sick, this man "blew in her face and she got well."

Shamans were also prevalent among the Indians of the Middle Yukon. They carried their medicine in a bag made of tanned newborn calf skin, but no one ever got to see inside. When a shaman went hunting, he gave the bag to his father who subsequently hid it in his shirt. Some families also owned medicine dolls. These dolls were made of weasel and had a carved wooden face with a hood and earrings. They were hung from the ridge pole, and were intended to take away all evil. [6]

Among the Ten'a of the Lower Yukon the shaman was again a dominant influence. Shamanistic power was often revealed at an early age. As with the Chandalar Kutchin, the first signs of shamanistic proclivity was apparently a divergence from characteristic behavior. A young man might refuse to work, preferring rather to lie down and sleep. When asked if he was sick he would reply in the negative. With the passage of time he began singing and whirling around and around. Frequently he went alone into the woods, usually with insufficient clothing. This peculiar behavior could last for a year. When the youth returned to his usual state the people felt he must be endowed with magical powers. [7]

When someone was ill or suffered an accident, the shaman was asked to find a cure. If the cure

was successful the shaman claimed to have discovered the cause of illness, usually some food, the spirit of which had become dangerous to the patient. He then issued instructions never to eat that particular food again, and most so instructed obeyed. When someone died, a shaman made his medicine privately to find the source of evil and then explained he could not find it in time to save the deceased. Called to aid a sick baby, the shaman, by daydreaming, discovered that in most instances the infant was suffering because the person who was reincarnated in the child had been irritated in some way.[7]

Few non-natives have ever witnessed a shaman at work. During the late 1930's, however, the Rev. J. W. Chapman, Episcopal minister at Anvik, was present during a shamanistic ritual:

> The patient was brought in and placed upon a deer skin in the center of the room. Two smoky fish oil lamps cast a feeble illumination over the group in the center and over the dim faces of the nearer spectators . . . the apparatus of the magician was simple. He had a light, squirrel skin parki, into which he thrust his head and arms. Excepting for this he was naked. His purpose seemed to be to catch the evil spirit responsible for the man's condition and to imprison it in the parki which he held over his head and arms. He stormed from one side of the room to the other uttering a peculiar chattering cry and wrenching his body with such violent muscular contortions that I marvelled at his endurance. He seemed to be seeking something under the shelves and in the corners of the room. Once he stopped and declared that it was "no use"; but encouraged by the cries of the spectators he redoubled his contortions and efforts. The din was terrific. How the patient survived, or whether the evil spirit was captured, or how disposed of, I do not know.[8]

Though the shamans possessed great power over their own people, their "medicine" was ineffective when dealing with the white man. Rev. Chapman offers the Ten'a explanation — the white man has no soul but is inhabited by the soul of a deceased Indian. Since the white man is therefore a ghost, he is not affected by the shaman.[8]

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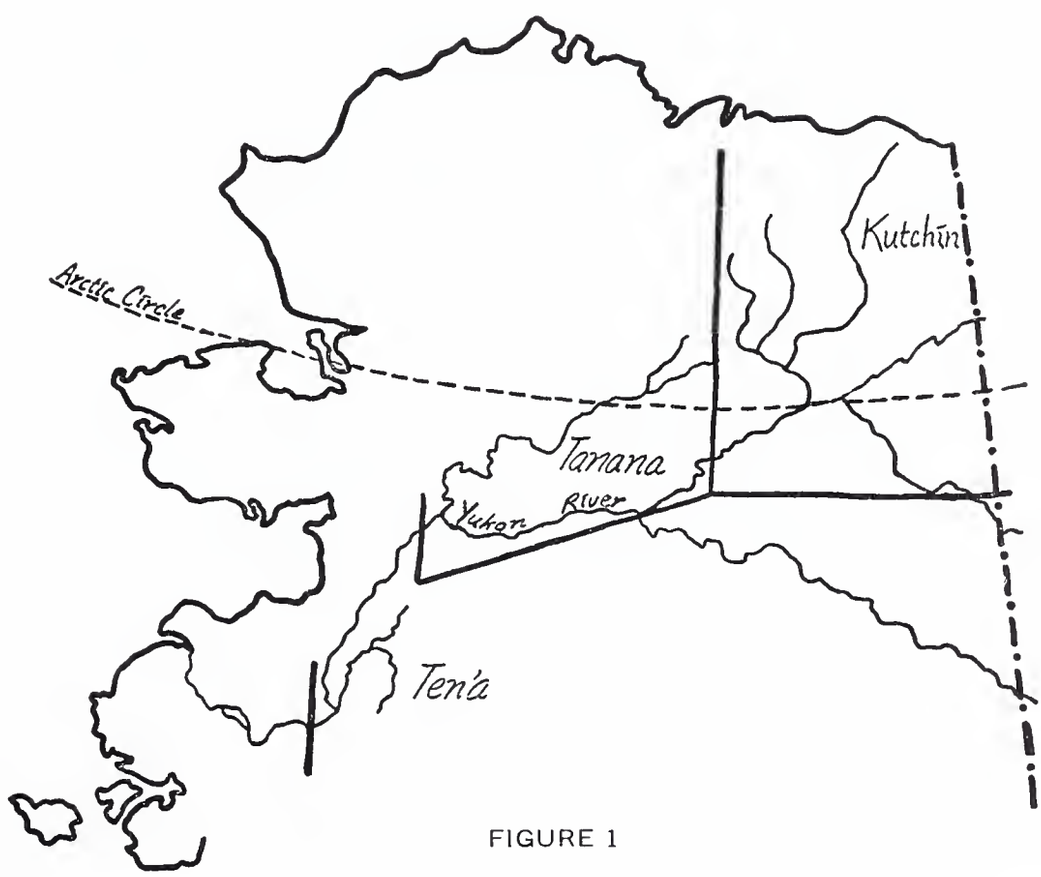


FIGURE 1

ALASKAN DRUG LAWS

What is prohibited and the penalties

By Ivan Lawner

In this review of the drug laws, I will not deal with such offenses as adulteration, mislabelling, keeping improper records, etc. This review will deal with the laws relating to the possession or sale of drugs by those who have no authority at all to possess or sell drugs. The drug laws of Alaska fall into two broad categories: those dealing with narcotic drugs, and those dealing with depressant, hallucinogenic and stimulant drugs.

Narcotic drugs are defined as coca leaves, opium, methadone and every other substance with similar physiological effects. The definition also includes all compounds, derivatives, salts, mixtures, preparations, etc. which have similar effects. Thus the term includes cocaine, heroin, morphine, codeine, etc.

A depressant, hallucinogenic or stimulant drug is defined as cannabis (marijuana, hashish and other derivatives), psilocybin, dimethyltryptamine (DMT), lysergic acid diethylamide (LSD) and every other substance having similar physiological effects; any drug which contains any of the salts of barbituric acid or any derivative designated by the Commissioner of Health and Welfare as habit forming and dangerous; any drug which contains amphetamine or its optical isomers, or a substance designated by the Commissioner as habit forming and dangerous because of its stimulant effect on the central nervous system; or any other substance designated as having a potential for abuse because of its depressant, stimulant or hallucinogenic effect.

Narcotic drugs - acts prohibited. It is unlawful for any person to manufacture, possess, have under his control, sell, prescribe, administer, dispense, give, supply or distribute any narcotic drug or compound except as authorized. Basically what this means is that one cannot possess, sell or give away a narcotic drug unless one possesses a license or prescription. Of course, there is a requirement that someone accused of possession or sale of narcotics must have knowledge of both the possession or sale and that the substance is a narcotic before he can be convicted. In other words, if someone has a narcotic in his house, the prosecutor must show that he knew it was there and he knew it was a narcotic drug.

PENALTIES

Offense	Minimum	Maximum
Any narcotics offense (sale or possession, etc.)		
1st offense	2 years	10 years $5,000
2nd offense (prior may be in another state)	10 years	20 years $7,500
3rd offense	20 years	40 years $10,000
Selling, giving, or supplying narcotics to a person under the age of 21 years		
1st offense	10 years and $5,000	30 years and $10,000
2nd offense (the prior offense being any narcotics offense anywhere in the U.S.	15 years	30 years and $25,000
3rd offense (any two narcotics priors)	life	life

Note: There is a provision in the statute providing that imposition or execution of sentences shall not be suspended for the above offenses, and that probation or parole shall not be granted until the minimum sentence provided has been served. However, judges do suspend sentences and the imposition of sentences and do grant probation under the authority of another statute. All the above narcotics offenses are felonies.

Mr. Lawner has been Legal Intern with the Alaska Public Defender Agency.

Depressant, hallucinogenic and stimulant drugs - acts prohibited. Basically the same acts of possession, sale, giving away and variations of these are prohibited under this category as with the category of narcotics. Guilty knowledge is also required here.

Offense	Minimum	Maximum
Possession or control of depressant, hallucinogenic or stimulant drugs for one's own use (Misdemeanor)	None	1 year or $1,000 or both
Possession or control of depressant, hallucinogenic, or stimulant drugs for sale or other disposal to another person or any other offense involving these drugs other than possession for own use (i.e. sale, manufacture, giving away, etc.) (FELONY)		
1st offense	None	* 25 years or $20,000 or both
2nd and subsequent offenses		Any term of years or life or $25,000 or both

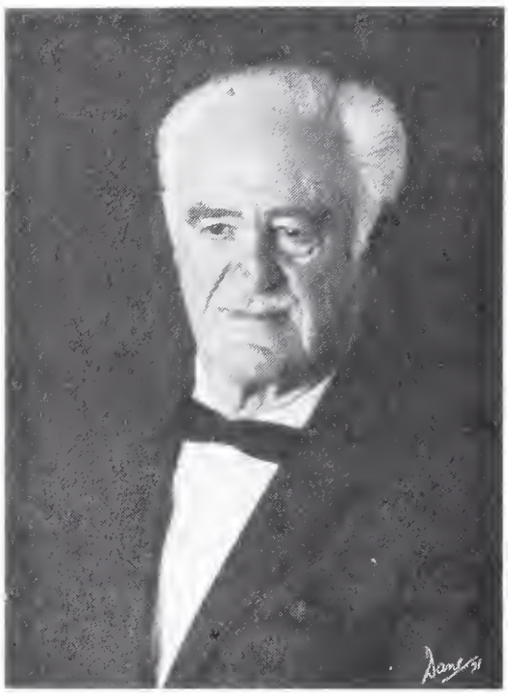
SENTENCING PRACTICES IN THE THIRD JUDICIAL DISTRICT AT ANCHORAGE

We looked through the files of the District Court and the Superior Court at Anchorage and noted all drug cases which were commenced and disposed of during the first six months of 1971. The overwhelming majority of both misdemeanor and felony defendants entered a plea of guilty or changed their plea to guilty. Among the misdemeanor possession cases (the great majority of which were possession of marijuana), the sentences ranged from six months deferred imposition of sentence with no fine to a jail sentence of 60 days. The fines ranged from $50 to $250 in Anchorage. The deferred imposition of sentence is the best possible outcome because the defendant can come out of it with a clean record. The deferred imposition of sentence works as follows: sentencing is deferred for a set period of time, perhaps a year, and the defendant is on probation during that time. If he satisfies all the conditions of probation, the primary one being that he violate no laws or perhaps no similar laws (i.e. drug violations), then at the end of the period of probation, he can come back into court, change his plea to not guilty, and the charges are then dismissed. If the defendant violates the conditions, however, he can then be given any sentence up to the maximum. Sometimes additional conditions were attached to the deferred imposition of sentence such as the payment of a fine. In between the two extremes were varying fines, and varying jail sentences. The most frequent sentences were jail terms of up to 90 days with all or most of the jail time suspended on condition that the defendant have no similar violations for a year. Frequently, part of the fine would also be suspended on the same condition. E.g. 60 days, 50 days suspended, $200 fine, $50 suspended. There were three cases which came from outlying areas such as Homer in which the magistrate had sentenced the defendants to 365 days, 180 suspended, and a fine of $1,000, $500 suspended. Those cases ended up in the Anchorage District Court because the guilty pleas were coerced and the defendants were then permitted to withdraw their guilty pleas and the cases were dismissed. The moral of the story is that if you are busted for possession outside of Anchorage, do not plead guilty before a magistrate. The magistrate's sentence in an outlying area is likely to be extremely harsh. Magistrates have been known to give the maximum of one year sentence on a first offense.

For felony offenses during the first six months of this year, the sentences were quite light. Most of the offenses involved the sale of or possession for sale of hallucinogenic drugs. The longest actual jail term handed out during that period of time was one year to serve, in a case of possession of hallucinogenic drugs for sale. There were several deferred impositions of sentence which were deferred for periods of one to three and one-half years. Conditions for some of the deferred impositions of sentence included payment of a $1,000 fine and serving 40 days in jail. Most of the jail sentences which were given without the deferred imposition, were nevertheless suspended on condition that the defendant fulfill all the conditions of probation, one of which would be that he violate no laws. The suspended sentences ranged from six months to three years. However, this period of time may not be very representative of the upper extreme of sentencing for felonies. Even though some of the sentences were for defendants in hard narcotics cases, it can be presumed by the sentences that the defendants were first offenders and just addicts, not big-time dealers. There are people in the State Jail now who were convicted either before January, 1971 or after June, 1971, who are serving actual jail sentences ranging from two years to fifteen years.

* It should be noted that Alaskan law provides for review of sentences in criminal cases by the Supreme Court. That Court has said that the maximum sentence should only be applied to the worst possible offender of the particular statute. It is probable that a first offender (e.g. a first offender selling or giving a small quantity of marihuana) sentenced to the maximum, would have his sentence reduced on appeal to the Supreme Court.

IN MEMORIAM*



Dr. Roderick Murray MacKenzie died in Sidney, British Columbia, on January 22, 1972, at the age of 69. Funeral services were held at Saanichton, British Columbia, on January 26. The scene was at St. Stephens, the small stone church at Saanichton, the site of which was given by members of his family, among the earliest settlers in the area. It still stands there, a prototype of the country church of those early years.

Born in Saanichton on December 8, 1902, Dr. MacKenzie attended school in Saanichton and Victoria and graduated from the North Pacific College of Dentistry in Portland, Oregon. He came to Alaska in 1925, where he began his career in dentistry in Nenana, later moving to Petersburg and then to Ketchikan, where he practiced until 1953. He was an excellent operator and an amateur artist. When the Alaska Dental Society was formed in 1950, he designed the official seal.

His resources of energy were such that they carried him into many activities beyond his work in the dental field; his enthusiasms were contagious and his persuasive powers prodigious, resulting inevitably in his entrance into politics. He was elected into the Territorial Senate in 1949, where he served one term, terminating in 1951. His comprehensive knowledge and understanding of dental problems resulted in his appointment as Director of Oral Health Activities for the U.S. Public Health Service, in which capacity he served for six years. Among his accomplishments in this service was the establishment of a training school for dental assistants in Sitka.

In 1958 he returned to Canada and practiced there until 1967. He was a member of the Pioneers of Alaska and was a Mason. He served on the Alaska Board of Dental Examiners and in 1960 was voted an honorary lifetime membership in the Alaska Dental Society. He is survived by his widow, Jean, of Sidney, B.C.; four daughters, Mrs. Roman Keleske and Mrs. Richard Miller, of Ketchikan; Mrs. Heather Myers, of Djakarta, Indonesia; and Mrs. Eric Page, of Palo Alto, California. Two sisters, Mrs. Jessie Kenney and Mrs. Mildred Ibbetson, of Sidney, B.C., and eight grandchildren also survive him.

(This memoriam to Rod McKenzie was prepared by J. P. (Jake) Valentine, a laboratory technician in Ketchikan, and life-long friend of Dr. McKenzie. Jake was the first honorary member of the Alaska Dental Society.) Ed.

ALASKA DENTAL SOCIETY CONVENTION
MT. McKINLEY PARK JUNE 4-7, 1972

DR. NARA FEATURED CLINICIAN AT 23rd A.D.S. CONVENTION

The Alaska Dental Society's 23rd annual convention will be held at Mt. McKinley National Park Hotel. Mt. McKinley National Park is readily accessible via the new Fairbanks-Anchorage highway or by way of the Alaska Railroad.

The convention will feature Robert O. Nara, D.D.S. as clinician. "Dr. Nara is a noted authority on preventive dentistry, personnel management and business management. He is a 1959 graduate of the University of Michigan, a member of Omicron Kappa Upsilon, and is the youngest Trustee of the Michigan Dental Association.

After graduation he served two years as a United States Naval officer, and then established his practice in Houghton, Michigan. He became totally involved in his mission in dentistry. Realizing the serious responsibility of patient care, education and motivation, it was essential to expand his practice, his physical plant and increase his staff.

Dr. Nara's deep concern for his patients prompted him to incorporate into his dental procedure a Preventive Dentistry program. This dedication to his patients has evolved into "Oramedics", a total patient care program. The success of Oramedics and his organizational ability, has for several years resulted in invitation to lecture throughout the United States and several foreign countries.

Although his profession has enveloped much of his life, he has found time to devote to his charming family, his dental society, and participate in various civic groups."

Information concerning the convention can be obtained by writing the convention chairman, Dr. Arthur S. Hansen, 3550-2 Airport Road, Fairbanks, Alaska 99701.

AURORA DENTATUS

ANCHORAGE

—Dr. Gerry Morrow presented her husband Phil another daughter, Lora Jean, 7 lbs. 4 oz., on 21 Jan. 1972.

—The Joe Harmons have their first child, a 7 lb. 14 oz. boy, Jason J., born 9 Jan 1972.

—Andrew N. Slisco has opened new offices in the Jewel Lake Professional Center, 8235 Jewel Lake Road.

—Gene F. Morton has also established his offices in the Sand Lake area, 7999 Jewel Lake Road.

—William A. Barrickman is now associated with Jim Harrower at 235 East Ninth Avenue.

—Thomas J. Munger III has associated with Glen Gould at 1080 Fireweed Lane.

—William Fell has established his office at 1020 Fireweed Lane.

—Mike Darling is in the progress of setting up his new office at 2044 East Northern Lights Blvd.

—Richard Pauli and Carroll Bledsoe will be moving to new space, 206 East Fireweed.

Dentistry's most promising dog musher, Dr. Richard Hanks, did very well this past season. He came in second in the Alaska State Championship races held in Kenai-Soldotna in late January, and was No. 6 in the Anchorage Fur Rendezvous World Championship dog races this past February. Dick and his wife Donna have a string of about 30-40 dogs which they train and race.

IMPORTANT MISCELLANY

ADA RELIEF FUND

Have you sent in your contribution to the ADA Relief Fund? So far Alaska has provided only 50% of its quota, not really very many dollars, and we could easily go over the 100% mark if a few more members sent in their checks.

WAMI PROGRAM

Our medical colleagues at the University of Washington not long ago came up with an educational concept which may well be a model experiment or pilot project for higher education in the medical and allied fields.

Dr. August Swanson, Associate Dean, University of Washington Medical School, in his studies made some interesting and important findings.

He found that men tend to practice medicine where they train. Which, in the Washington, Alaska, Montana, Idaho group, means that the out-of-staters infrequently return to their home states, but remain in the Seattle area after training at the University of Washington. A possible solution to this is to split the freshman class, and teach basic sciences in the respective home states. In our case the University of Alaska at Fairbanks had 9 freshmen medical students last semester. This also kept the size of the freshman class at the University of Washington more manageable.

Dr. Roy Schwarz is currently administrator for the WAMI program and is operating under a three year grant. He and his committee recently visited Alaska to evaluate the program's past year's performance as well as to explore the expansion of this program to include Dentists and their ancillary personnel.

The Medical and Dental students from Alaska are in fact subsidized to some extent by an inter-state arrangement called WICHE (Western Interstate Commission for Higher Education). The Washington legislature is raising some question about the amount of Alaska's participation; and meetings have been held by Dr. Schwarz's committee and our state legislature finance committees.

IRRESPONSIBLE JOURNALISM

Not too many years ago a short, loud German named Adolf, writing a book while ensconced in the local clinic, came up with the idea that if he repeated a lie, no matter how big, often enough, every one would sooner or later believe it to be the gospel truth. Adolf, happily is no longer with us, but his theory, screwy as it seems, is still pure gold.

Advocates of socialized medicine and dentistry, both in government and out are using Adolph's theory with pretty good results, for more and more United States citizens think they want it, that is free and of good quality. A good current example of material that the public gets appeared in the Anchorage Daily News, 19 March 1972 in an article "A New Look At Britian's Socialized Medicine" by Anthony Collings. It's time to tell the truth instead of half truths and lies.

R. A. Smithson, D.D.S.

ON THE USE OF PROBLEM-ORIENTED MEDICAL RECORDS

By Allen J. Jervey, M.D.

It is perhaps trite but nonetheless true to note that medical knowledge is expanding at an explosive rate. The number of diagnostic and therapeutic modalities at a physician's fingertips have greatly increased his capacity both to benefit and to harm his patients. If he is to take greatest advantage of them and to minimize errors of omission and commission, it is essential that an orderly and systematic method of keeping medical records replace the existing random diffuse methods, or more accurately, non-method. With the earlier non-method, observations are often recorded as vague and scattered entries in the patient's record, with the result that they may be overlooked and lost in a morass of unrelated notations. Potentially remediable problems may then be missed, and accurate monitoring of the treatment and progress of multiple, perhaps inter-related, problems becomes impossible. In an attempt to improve this state of affairs, Dr. Lawrence Weed created his problem-oriented approach to medical records. He explains this system fully in his book *Medical Records, Medical Education, and Patient Care.* I will attempt to summarize these ideas in a succinct fashion, but refer you to the book for a complete and detailed explanation of its use.

It is obvious that no system will of itself improve medical care. It can not be better than the individual who uses it. What problem-orienting a chart does is to provide a methodology which enables the physicians, nurses, and para-medical personnel involved in the patient's care to focus their attention on specific problems, and to deal with them in a systematic fashion. Just as importantly, it makes it less likely that problems not of immediate concern to a given physician, but possibly of great concern to the patient, will not be overlooked in the flurry of caring for more pressing or interesting problems. In this sense, this system forces attention to be paid to the entire patient with all of his problems, not just those of immediate or special interest to the physician.

Weed defines four basic elements of a problem-oriented medical record: 1) the *data base*, consisting of the history, physical examination, and basic laboratory and screening tests. 2) the *problem list*, which is derived from the information obtained in the data base. 3) the *initial plan*, which is outlined for each problem that has been identified, and 4) the *progress notes*, which are numbered according to the problem they pertain to, and should provide accurate monitoring of the diagnostic and therapeutic steps being taken for each problem during the course of the patient.

The data base begins with the patient profile, which is a description of just what sort of a person the patient is and how he is presently spending his time. In essence, this is an expanded social history. Once this picture of the patient is obtained, it should be borne in mind throughout the care of that patient, so that plans are not formulated which are grossly inappropriate for a particular individual although appropriate to the problem out of the individual pattern context.

The present illness follows, and is labeled as a problem, defined as accurately as possible. For example, if the reason for admission is a chronic problem with an established diagnosis, it should be labeled as such, e.g., "ASHD with CHF". If it is a new problem and a diagnosis is not apparent, it is labeled as closely to the patient's chief complaint as possible, e.g. "Dyspnea". The history is then broken down into subjective and objective headings. The former consists of the symptoms the patient expresses. The latter is information accumulated with laboratory tests, or observations made during previous office visits or hospital admissions, which relate to the problem being considered. Thus, if the problem is diabetes mellitus, a previous G.T.T. and fractional urine glucose tests would be important objective data. The data on which the diagnosis is made, and some idea of the extent of the disease, are thus readily available in a logical place.

A third subdivision of the present illness is "Rx" which includes therapy given by physicians or initiated by the patient. If the patient has more than one problem which has led him to seek medical attention, it should also be included in the present illness with its own problem number, title, and description as discussed above. In effect any active problems should be entered under the present illness. The remainder of the initial work-up is done in the customary fashion except that social history would be incorporated into the patient profile. The past history in all of the inactive problems.

After completing this process and obtaining basic screening laboratory data called "health surveillance", which should be appropriate for the age and sex of the patient, one next formulates the problem list. It is apparent that the problem list will only be as complete as the data base. If a

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Dr. Lawrence L. Weed will "appear" at the Alaska Health Congress June 1, when he will be interviewed via satellite.

cursory history and physical examination are performed, it is not likely that all of the problems of the patient will be identified. Only by identifying all problems can total patient care be delivered and the medical profession is increasingly being criticized for not providing this. A problem should be delineated as precisely as possible at that time. It can be (1) a diagnosis followed by the principal manifestation that requires management, e.g., "ASHD with CHF" or (2) a physiologic finding, e.g., "edema of unknown etiology" or (3) a symptom or physical finding or (4) an abnormal laboratory value or (5) a sociologic or psychiatric problem or (6) a demographic problem, i.e., potential problems that a patient is at a high risk of developing.

If a problem has several manifestations requiring separate careful management, it simplifies matters to list it as a subheading or entirely separate problem. Thus, if the problem is No. 1 "ASHD with CHF" and an arrythmia develops, it could be listed either as No. 1 a"Supraventricular tachycardia" or as No. 2 "Supraventicular tachydardia 2° to No. 1. If a problem arises that likely will be transient and insignificant, it can be carried as a "temporary problem" in the chart and not entered on the problem list unless it turns out to be more significant than it initially appeared. Question marks and rule-outs are not problems and should not appear on the problem list. The problem should be defined as exactly as possible without making guesses. It is better to keep an open mind about possible etiology. Once the complete problem list is formulated it should appear on the first page of the patient's chart for easy reference. The left hand half of the sheet is used for active problems and the right side for resolved or inactive problems.

Once this is accomplished, the physician is ready to formulate his initial plan for each problem. The plan may contain three categories: diagnostic, therapeutic, and patient education and is entered under the appropriately numbered problem. It is here that rule-outs are listed followed by the planned diagnostic tests. For instance, such a plan might be constructed as follows:

No. 1. Chest pain of undetermined etiology.
Plan: R/o Angina pectoris
Dx: Master's Test
Rx: Nitroglycerin trial PRN

R/o Pulmonary lesion
Dx: Chest x-ray

R/o Musculoskeletal pains.
No plan pending above studies.

Patient education becomes especially important once a diagnosis is established and specific therapy begun. Numerous recent studies of patient compliance with medication orders have found that most patients take only a small fraction of the medicine prescribed for them. In order to obtain the cooperation of a patient, he must understand something of the nature of his illness and how the prescribed therapy will benefit him. With increasing medical sophistication, the public has become less willing to accept the doctor's orders as articles of faith.

The preceding three parts of the medical record comprise the initial evaluation. As the patient is followed in the office or hospital, progress notes record the results of diagnostic and therapeutic efforts for each problem listed. Progress notes are divided in the same way as the present illness, with appropriately numbered problems, following the heading "Subjective", listing how the patient is feeling generally and specific symptoms relevant to the problem while including pertinent lab results, physical findings and similar information under "Objective". This is then summarized as an impression or assessment of the progress in defining or treating the problem. Finally, any further plans are listed under the heading "Plan". An example of such a progress note follows:

No. 1 Chest pain of ? etiology-musculoskeletal pain.

Subj: Feels well. Pain improved. nitroglycerine → no improvement.

Obj: Master's Test negative, EKG normal, Chest x-ray normal, lungs clear to auscultation and percussion. Local tenderness 5th and 6th ribs anteriorly.

Imp: Angina or pulmonary lesion unlikely and etiology probably is musculoskeletal. Symptoms improved now.

Patient Education: Explained that no evidence of heart or lung disease was found, and that pain is related to muscular strain.

Plan: No further work-up. Problem resolved.

At this point the original problem list is consulted and problem updated. If the problem is felt to be resolved and no longer active, an arrow is drawn across the page to the resolved, inactive side with the date above the arrow indicated when this was done. If the problem is resolved in the sense that a symptom becomes a diagnosis but the diagnosis is of an active problem, an arrow is again drawn to the resolved side with the date of the progress note establishing the diagnosis. The diagnosis is then entered as a new problem with its own number under the active problem list and the original problem is dropped. Thus, if a patient had on admission only one problem, e.g., "chest pain" and after four days, a diagnosis of lung CA is established, it would be written:

ACTIVE		RESOLVED
No. 1	Chest pain - 6/14/70 →	2° to No. 2
No. 2	Carcinoma of lung with chest pain.	

In following a patient's course it is often more helpful to compose a flow sheet in which specific parameters of problems are selected and charted. This portrays a more graphic and informative picture of the chronologic course of a problem and how it responds to therapy. It is certainly much easier and faster to look at a flow sheet than to search through progress or office notes that could cover years in chronic problems. It can also provide invaluable help in monitoring severe, acute complicated problems with multiple interacting parameters such as renal failure with congestive heart failure.

We have found it helpful to have para-medical and nursing personnel writing problem oriented notes in the patient's record in the same place as physicians. This means that some of the non-specific verbiage, e.g., "quiet night" must be eliminated. In many cases, physical therapists, dieticians, and nurses may have more intimate contact with the patient, and are in as good a position to assess his progress, as the physician is.

The logical extension of this system is to computerize each patient's history under specific problems so that the entire data for a specific problem or a complete patient's chart could be instantly available in an organized fashion.

This concludes my attempted summary of Dr. Weed's system. His book presents his approach in a much more detailed and explicit fashion. I heartily recommend it or Bjorn and Cross's *Problem Oriented Practice* which discusses its implementation in a small private practice in Maine, for anyone interested in pursuing the subject further.

Portrait of Dr. Laurence Irving

Presented to the Laurence Irving Building, Institute of Arctic Biology by Dr. and Mrs. Arthur Schaible.

NORTHERN HIGHLIGHTS

Selected Abstracts on Medicine in the North

(This column, if interest warrants, will be a regular feature of Alaska Medicine. Each issue will contain abstracts or resumes of recent papers from other journals on medicine in the arctic and subarctic regions. — Ed.)

ASEPTIC MENINGITIS AT KOTZEBUE:

Kaplan, G. J., Clark, P.S., Bender, T.R., *et al:* Echovirus type 30 meningitis and related febrile illness: epidemiologic study of an outbreak in an Eskimo community. *Amer. J. Epidem. 92:* 257-265, 1970.

During the fall of 1969 a substantial outbreak of aseptic meningitis and related illness due to echovirus 30 occurred in Kotzebue. This paper describes the epidemiologic and laboratory investigations which were undertaken jointly by the Arctic Health Research Center and the Ecological Investigations Program of NCDC.

The epidemic began on August 28 and ended November 4. During this period 53 cases of "aseptic meningitis" (defined as headache, vomiting, fever, and stiff neck) and 107 cases of "related febrile illness" (headache, vomiting, and fever without neck stiffness) were identified, either from hospital records or from a family illness survey. The age of patients ranged from 3 months to 65 years, with the highest attack rates in the 5 to 14 age group. The sexes were equally affected. No geographical clustering was apparent. No deaths were reported, nor were there any complications.

Virologic studies included culture of the agent in WI 38 tissue lines and neutralization tests on paired or convalescent sera. Forty-four percent of throat swabs and 41% of rectal swabs tested were positive for echovirus 30. Fourfold antibody rises were demonstrated in 63% of paired sera. Virologic and serologic studies were positive in 17/30 patients with aseptic meningitis and 29/42 patients with related febrile illnesses.

The origin of this outbreak could not be determined but in recent years the virus had spread northward in a series of epidemics from California. It is likely that the population of Kotzebue has had little previous exposure to this agent.

BOTULISM - TYPE E:

Stuart, P.F., Wiebe, E.J., McElroy, R., *et al:* Botulism among Cape Dorset Eskimos and suspected botulism at Frobisher Bay and Wakeham Bay. *Can. J. Public Health 61:* 509-517, 1970.

This paper describes a bacteriologically confirmed outbreak of botulism at Cape Dorset and suspected outbreaks at Frobisher Bay and Wakeham Bay, all in the Canadian Eastern Arctic. The authors are with McGill University and several Canadian government agencies.

In the first outbreak, 10 Cape Dorset Eskimos ate parts of a harp seal which had been lying outdoors for nearly the whole summer. Three individuals died within 30 hours and the fourth had typical symptoms but recovered. Six others ate very little and were probably unaffected. No botulinum antitoxin was available at the local nursing station or at the hospital in Frobisher Bay; in fact, none but types A and B were available even in Montreal. Type E antitoxin was finally located in Toronto and belatedly flown to Frobisher Bay, where the survivors had been evacuated.

A pure culture of *Cl. botulinum* type E was isolated from the stomach contents of two of those who died and from a piece of seal meat. Type E toxin was also demonstrated.

In another outbreak, three Eskimos at a hunting camp near Frobisher Bay died after eating partially decomposed seal meat. Five others in the camp, none of whom ate the meat, remained unaffected. A sample of the meat was later shipped to Ottawa, where *Cl. botulinum* type E was isolated.

At Wakeham Bay an Eskimo died after eating portions of a walrus, the meat of which was said to be spoiled. No specimens were recovered, nor was medical care available for the victim.

It is of interest that now botulinum antitoxin of types A, B, and E are available at seven hospitals and 30 nursing stations throughout the Canadian arctic.

The authors conclude by discussing the feasibility of active immunization of Eskimos with botulinum toxoid.

Botulism - Alaska. *Morbidity & Mortality Weekly Reports, Vol. 20,* No. 41, Oct. 16, 1971.

In mid-July 1971, a 29 year old Eskimo woman from Bethel was admitted to the local hospital with nausea, vomiting, diarrhea, dry mouth, hoarseness, and "tired eyes". She later became apneic, and after resuscitation was transferred to the Alaska Native Medical Center in Anchorage, where she received botulinum antitoxin some 3 days after onset of symptoms. Type E toxin was found in her serum. She gradually improved and was discharged essentially well.

The patient's 15-year-old nephew from Kasigluk developed a similar clinical picture and was promptly treated with botulinum antitoxin at the Bethel Hospital. Type E toxin was also found in his pre-treatment serum. He recovered uneventfully.

Investigation showed both patients had eaten some lightly-smoked whitefish in Kasigluk 30-72 hours before symptoms began. *Cl. botulinum* type E toxin was recovered from a sample of the whitefish. Others who had eaten the fish were unaffected.

FISH TAPEWORM:

Rausch, R.L., Hilliard, D.K.: Studies on the helminth fauna of Alaska. XLIX. The occurrence of *Diphyllobothrium latum* (Linnaeus, 1758) (Cestoda: Diphyllobothriidae) in Alaska, with notes on other species. *Can. J. Zoology 48:* 1201-1219, 1970.

This paper on the fish tapeworms of western Alaska has special clinical significance for physicians practicing in the arctic and subarctic. The authors are with the Arctic Health Research Center in College, Alaska, and the work reported here spans a 21-year period of study.

Five distinct species of the genus *Diphyllobothrium* were recovered from man, chiefly from Eskimos of the Yukon-Kuskokwim Delta region. The bulk of the paper is devoted to a detailed morphological study of 60 specimens of *D. latum* from Alaska, with appropriate comparisons

from the European scientific literature. Man appears to be the only important final host for *D. latum*, while the intermediate stage hosts for this species in Alaska are still obscure.

Other species recovered from man, as well as other animals, were *D. dendriticum, D. lanceolatum, D. ursi,* and *D. dalliae.* The common definite hosts for these species include gulls, dogs, seals, bears and foxes.

Man and other animals acquire these parasites by the ingestion of insufficiently cooked fish containing the larval plerocercoid form. Such fish may include trout, whitefish, red salmon, and blackfish. Several infections have been found in Caucasians from the Anchorage area.

Fish tapeworms are common throughout Arctic America and are probably indigenous, although the outside possibility exists that *D. latum* was introduced by Europeans in the late 18th century.

SHIGELLOSIS AT SITKA:

Clark, P.S., Noble, G.R., Maynard, J.E., Barrette, P.: Shigellosis in Sitka, Alaska, 1968. *HSMHA Health Reports 86:* 173-178, 1971.

This report describes a large outbreak of bacillary dysentery which occurred in Southeastern Alaska during the spring of 1968. The epidemic was studied by the Ecological Investigations Program of the National Center for Disease Control in cooperation with the Alaska Division of Public Health.

A total of 301 cases of clinical illness were reported from 116 families. Twenty-six of these were associated with a positive culture for *Shigella sonnei*, as was one asymptomatic carrier. Of the 116 families reporting illness, a substantial majority experienced "secondary" cases, that is, cases developing within the family more than 48 hours after the index case. This finding, together with the fact that the cases were distributed throughout the community and over nearly three months in time, supports the likelihood that the epidemic was spread by person-to-person contact rather than from a common source.

The overall attack rate for the epidemic was 9%, with the 5 to 9 and 10 to 14 age groups having rates of 24% and 28% respectively. A curious feature of this outbreak was the fact that illness occurred preferentially in the middle socio-economic level households. Many of these families lived in trailers, however, and crowding may have been a contributing factor to the easy spread of the organism.

LIPID PATTERNS IN GREENLANDERS:

Bang, H.O., Dyerberg, J., Nielsen, A.B.: Plasma lipid lipoprotein pattern in Greenlandic West-Coast Eskimos. *Lancet 1:* 1143-1145, 1971.

The authors, from the Aalborg Hospital in Denmark, measured the plasma total lipid, cholesterol and triglycerides and performed lipoprotein electrophoresis on plasma samples from 130 Eskimos over 30 years of age living in the Umanak region of Northwest Greenland. The people of this district subsist largely on sea-mammal meat and fish. Ischemic heart disease and diabetes are rare in this group.

Compared with healthy Danish controls, the Eskimos, both male and female, had in most age groups significantly lower values for cholesterol, triglycerides, pre-beta-lipoproteins, and beta-lipoproteins.

A small group of Eskimo women living in Denmark were compared with a group of women from Greenland. The Danish group had significantly higher plasma lipid and lipoprotein values, comparable to those in Caucasian Danes.

The authors speculate that these differences are probably due to dietary habits rather than to genetic variation. The diet of the Greenlanders contains large amounts of polyunsaturated fats.

HEALTH AND THE H B C:

Burgess, H.: Health by remote control, *The Beaver*, Winter Outfit, 1970, pp 50-55.

This article describes the early efforts of the Hudson's Bay Company to improve the health of its traders in the remote posts of Northern Canada. Some of the measures that were initated had a significant impact on the health of the Eskimos and Indians who frequented the trading posts.

The Company, concerned about the poor health of its northern employees, hired a group of distinguished medical nutritionists in the late 1930's to serve as consultants. These physicians surveyed the northern posts and found the health of the traders, as well as that of the Indians and Eskimos, to be poor. Particularly common were dental problems, weight loss, and a condition known as "bush stomach". As a result of their findings, the Company instituted a health education program on the benefits of good nutrition, improved the nutritive value of canned goods available at the posts, and encouraged the use of garden plots for vegetables. Milk products were also made more readily available, as was an enriched form of white flour. The traders experimented with freezing fresh foods for long periods.

When sulfas and penicillin became available after World War II, the Company stocked them at the posts for use in emergencies. A medical self-help manual was also prepared by the company for the use of traders. Short-wave radios brought the trader within reach of professional consultation when it was needed. The HBC trader, though still important in some remote areas as a health advisor, has now relinquished much of his old responsibility.

—Robert Fortuine, M.D.

BOOK REVIEW

WHY WEED?

THE PROBLEM ORIENTED PRIVATE PRACTICE OF MEDICINE — a system for comprehensive health care. By John C. Bjorn M.D. and Harold E. Cross M.D. 145 pp., illustrated with appendices. 1970. Chicago: Modern Hospital Press.

MEDICAL RECORDS, MEDICAL EDUCATION, AND PATIENT CARE. By Lawrence L. Weed M.D. 267 pp., illustrated, with appendices. $9.95. 1969. Chicago: Year Book Medical Publishers Inc.

Medical records are Dullsville. Every medical student learns that, and every doctor who is hounded by his nurse, records librarian, insurance adjustor, or lawyer, has learned to place medical records in Priority Z. But stay! a quiet revolution is spreading across the medical scene that many of you may not be aware of, and there are several reasons why you should be.

Doctor Lawrence L. Weed, Professor of Medicine at the University of Vermont, has invented a system of medical records-the"Problem-Oriented-Record"-which converts the bulky jumble of medical observations that we all know as the "patient's chart" into a precision tool for medical care. Only a few physicians in the Anchorage area seem familiar with it yet, but the "Problem-Oriented-Record" is now being introduced into the Alaska Native Medical Center. Dr. Allen T. Jervey, internist at ANMC, took his residency under Doctor Weed, knows the system first hand, and has very nicely outlined its basic concepts in an article in this issue.

The advantages of the system would appear to be:

1. It makes information readily retrievable from medical records.
2. It makes the medical record pertinent to the patient's medical care.
3. It saves time.
4. It can make the practice of medicine more fun.
5. It ties in with the use of computers, hospital-centered medical care, preventive medicine, multiphasic screening, health maintenance organizations, socialized medicine, and similar aspects of the Medicine of the Future, in whatever form it takes.
6. It makes medical auditing, peer review (or whatever term the review of medical records goes by), an easier process. Since whoever pays the piper calls the tune, for example insurance companies and the Social Security Administration, such agencies may well at first recommend, and perhaps eventually insist upon, a more efficient method of record review than the present crisis-oriented record permits.

Doctor Harold E. Cross of Hampden Highlands, Maine, learned the system from Doctor Weed many years ago, taught it to his new partner Doctor John C. Bjorn in 1963, and they have used it exclusively ever since in their small-town family practice. The two describe the application of the system in detail and with enthusiasm in the book *The Problem Oriented Private Practice of Medicine - a system for comprehensive health care.* This book is probably the best available introduction to the problem-oriented record and will whet your appetite for the classic description of the system by the originator — Doctor Lawrence L. Weed's *Medical Records, Medical Education, and Patient Care.* Both books are available at the Alaska Health Sciences Information Center. Mrs. Strash also has available a collection of various articles pertinent to the system.

F. J. Hillman, M.D.

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2. Weed L. L.: Medical records that guide and teach. *N Engl J Med.* 278:652-657, 1968.
3. Weed L. L.: What physicians worry about: How to organize care of multiple-problem patients. *Mod. Hosp.*, Vol 110, pp 90-94 June 1958.
4. Weed L. L.: CPC's as Educational Instruments. *N. Engl J Med.* Vol 285:115-118, 1971.
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6. J. Willis Hurst: Ten reasons why Lawrence Weed is right. *N. Eng J Med* 284:51-52 Jan. 1971.
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8. Schulman J and Wood C: Flow Sheets for charts of ambulatory patients. *JAMA* Aug 16, 1971: Vol 217, No. 7 pp 933-937.
9. Cross HD and Bjorn JC: The problem-oriented medical record. *Med. World News,* May 7 1971 pp 31-40.

SURGERY & BIOLOGY OF WOUND REPAIR

Earle E. Peacock Jr., M.D., Walton Van Winkle Jr., M.D., W. B. Saunders Co. 1970, 630 pages.

This book is a concise and modern summary of the physiology and biochemistry of wound healing. The basic processes involved in tissue repair are thoroughly analyzed in the first part of the book. The second part discusses the application of these ideas to the healing of specialized tissues such as tendon, bone, muscle, nerve and viscera. This section will be of real value to surgeons, as it applies an extensive clinical as well as theoretical experience to specific problems of healing. It is a valuable book and highly recommended to surgeons in all fields.

Theodore Shohl, M.D.

MODERN TREATMENT – November 1970

Management of Esophageal Disease,
ed. T. M. Bayless, M.D.

This 275 page book contains twenty-one articles by thirty contributors. It is an excellent, yet dangerous, book. Excellent because many different viewpoints are expressed; dangerous for the same reason. It should be digested over a couple of long evenings, then argued out at leisure. It would be a lousy book to rush into for advice in an emergency, especially for one not familiar with the field, since it is a review designed to update, not a complete in-depth manual on how to do.

Some of the many suggestions for diagnosis and treatment are sensible and excellent, but a few strike me as unnecessarily complex, even nonsense. A physician without preconceived ideas on esophageal disease might well be puzzled when one author recommends dilation of an obstructing carcinoma while another roundly condemns this. Or again, depending upon where one opens the book, one is advised that impacted meat in the esophagus can easily and safely be dissolved with meat tenderizer, or that one should always avoid meat tenderizer, since the ischemic esophagus may dissolve simultaneously.

A number of hard-to-interpret tests for acid sensitivity, pressure, and pH within the esophagus would seem to add unjustified expense to the care of most

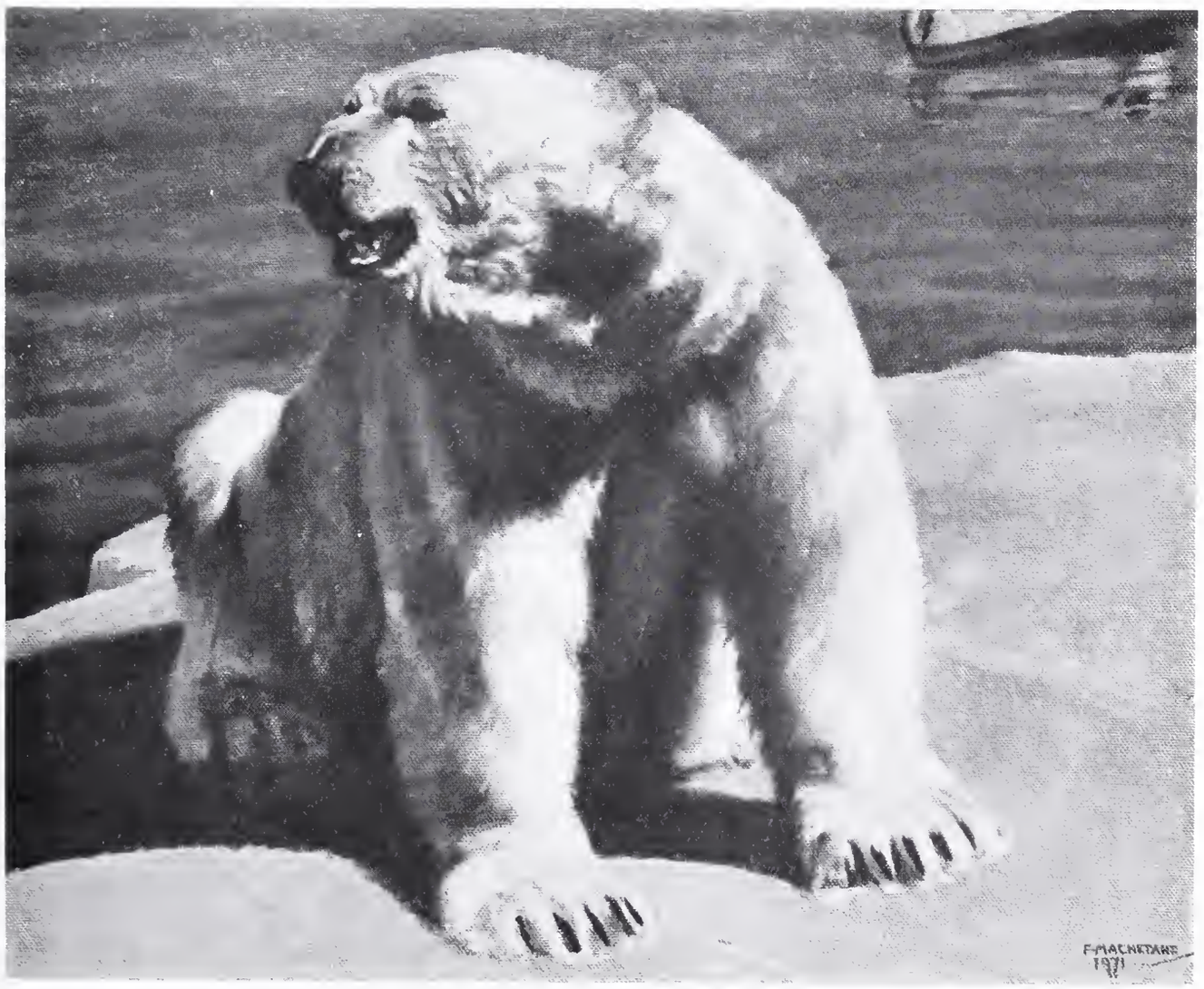
patients. After all, a good history and x-ray findings of hiatus hernia with reflux are diagnostic enough in most cases. I find it difficult to imagine a proper indication for the passage of a complex diagnostic tubing apparatus that is guaranteed traumatic enough to the masked cardiac patient to cause diagnostic ST-T changes (even if the step test was negative). One remarks here on a blurring of the margin between clinical research and the treatment of the private patient of limited means and patience, who wants to get back to work. I would also condemn the suggestion for routine esophagoscopy and biopsy to prove reflux esophagitis.

No article mentions the hiatus hernia that is only temporarily symptomatic because of stress or forced recumbency with illness. The symptoms that flare up in pregnancy, marriage, acute disease, menopause, or jail will usually subside when life returns to normal, and certainly one prefers not to add to surgical stress at these times. The decision then, is between medical therapy, which will be adequate in the large majority of cases, and surgery. Via abdomen or chest, an uncomplicated repair should reconstitute the gastro-esophageal angle and secure a significant length of esophagus within the abdomen, regardless of preoperative pH or pressures.

I came away from this book impressed by the fact that major esophageal disease is uncommon in this country, except related to hiatus hernia. Almost all of the experts suffer from a small series, some even using single cases to prove a truth. Many disagreements noted between these authors are likely due to limited experience or pure hypothesis replacing the scientific method. A double-blind study is out of the question, however, with the small numbers of highly variable cases reported thus far. Today, esophageal disease is generally handled in community hospitals, hopefully by well-trained thoracic or general surgeons. There is no substitute for experience, especially first-hand rather than related via a surgical resident or recent article of dubious worth in the literature. Indeed, I often wonder if practicing physicians do not have a few tricks to teach the experts.

In summary, you may find little new here, yet this book provides an excellent in-depth review of an interesting subject. I have ordered a personal copy. I recommend it to you if you have time to read and colleagues willing to discuss it before the occasion arises.

Arndt von Hippel, M.D.



Imperiled Monarch — By Fred Machentanz
Collection of Mr. and Mrs. Earl Jordan.

Books Received

1. The Illness of Trauma, Garrett Pipkin, M.D. and Victor Buhler, M.D., Charles C. Thomas publisher, 301-327 E. Lawrence Ave., Springfield, Ill., price $12.75.

2. Doctors in Hospitals, Milton I. Roemer and Jay W. Freidman, published by Johns Hopkins Press, Baltimore, Md., price $12.50.

3. Alcohol and the Impaired Driver, Committee on Medicolegal problems AMA, published by AMA, price $1.00.

4. Synopsis of Pediatrics, James G. Hughes, B.A., M.D., published by C. V. Mosby Co., 3207 Washington Blvd., St. Louis, Mo., 63103, price $14.50, third edition.

5. Review of Physiological Chemistry, Harold A. Harper, 13th edition, published by Lange Medical Publications, Los Altos, Calif.

6. The Human Heart, a Guide to Heart Disease, second edition, by Brendan Phibbs, C. V. Mosby Co. publishers, 3207 Washington Blvd., St. Louis, Mo. 63103, price $5.75.

7. Medical Jurisprudence, by Jon R. Waltz and Fred E. Inbau, published by MacMillan Company, New York, price $10.95.

8. Physiology of Reproduction, William O. Odell, M.D. and Dean L. Moyer, M.D., published by C. V. Mosby Co., 3207 Washington Blvd., St. Louis, Mo. 63103.

9. Concepts of Disease, edited by Joel G. Brunson, M.D. and Edward A. Gall, M.D., published by MacMillan Co., 866 Third Avenue, New York 10022, price $23.95.

10. Guides to the Evaluation of Permanent Impairment, AMA published.

11. Autologous Transfusions, Langston, Milles and Dalessandro, published by C. V. Thomas Co., 3207 Washington Blvd., St. Louis, Mo. 63103, price $11.75.

12. Symposium on the Functional Physiopathology of the Fetus and Neonate, edited by Harold A. Abramson, C. V. Mosby Co., 3207 Washington Blvd., St. Louis, Mo. 63103.

13. The Tenth Bronfam Lecture, by Walter McNerney, President Blue Cross Association, printed for the American Public Health Association by The Columbia Printing Co., Hamden, Conn.

14. Modern Treatment Volume 7, No. 6, Management of Esophageal Disease, Guest Editor Theodore M. Bayless, M.D., published by Harper and Row, Inc., Medical Dept., 49 East 33 St., New York, N.Y. 10016.

15. Management of High-risk Pregnancy and the Intensive Care of the Neonate, second edition, S. Gorham, Babson and Ralph C. Benson, published by C. V. Mosby Co., 3207 Washington Blvd., St. Louis, Mo. 63103, price $16.50.

16. Doctor and Patient and the Law, fifth edition, R. Crawford Morris and Alan R. Moritz, published by C. V. Mosby Co., 3207 Washington Blvd., St. Louis, Mo. 63103, price $24.50.

17. Rehabilitation Medicine, third edition, Howard A. Rusk, published by C. V. Mosby Co., 3207 Washington Blvd., St. Louis, Mo. 63103, price $21.00

18. Shands Handbook of Orthopedic Surgery, eighth edition by R. Beverly Raney, Sr., and H. Robert Brashear, Jr., published by C. V. Mosby Co., 3207 Washington Blvd., St. Louis, Mo. 63103, price $15.50.

19. Synopsis of Ophthalmology, William H. Havener, third edition, published by C. V. Mosby Co., 3207 Washington Blvd., St. Louis, Mo. 63103, price $12.75.

20. Lumbar Disc Disease, a twenty-year clinical follow-up study, edited by Nashold and Hrubec, published by C.V. Mosby Co., 3207 Washington Blvd., St. Louis, Mo. 63103, price $16.50.

21. The Immunological Surveillance, Sir Fran MacFarlane Burnet, edited by Pergamon Press Inc., Maxwell House, Fairview Park, Elmsford, N.Y. 10523, price $7.75.

22. Current Diagnosis and Treatment, Marcus A. Krupp, M.D. and Milton J. Chatton, M.D. and Associate Authors, published by Lange Medical Publications, Los Altos, Calif. 1972, price $11.00.

23. Approach to the Medical Care of the Sick Newborn, Pierog-Ferrarra, published by C. V. Mosby Co., 3207 Washington Blvd., St. Louis, Mo. 63103, price $11.50.

24. Pediatric Therapy, edited by Shirkey, published by C. V. Mosby Co., 3207 Washington Blvd., St. Louis, Mo. 63103, price $34.50.

25. Introduction to Hematology, Dougherty, published by C. V. Mosby Co., 3207 Washington Blvd., St. Louis, Mo. 63103, price $10.50.

26. Understanding Laboratory Medicine, Bologna, published by C. V. Mosby Co., 3207 Washington Blvd., St. Louis, Mo. 63103, price $9.80.

27. Current Concepts in Dyslexia, edited by Hartstein, published by C. V. Mosby Co., 3207 Washington Blvd., St. Louis, Mo. 63103, price $12.00.

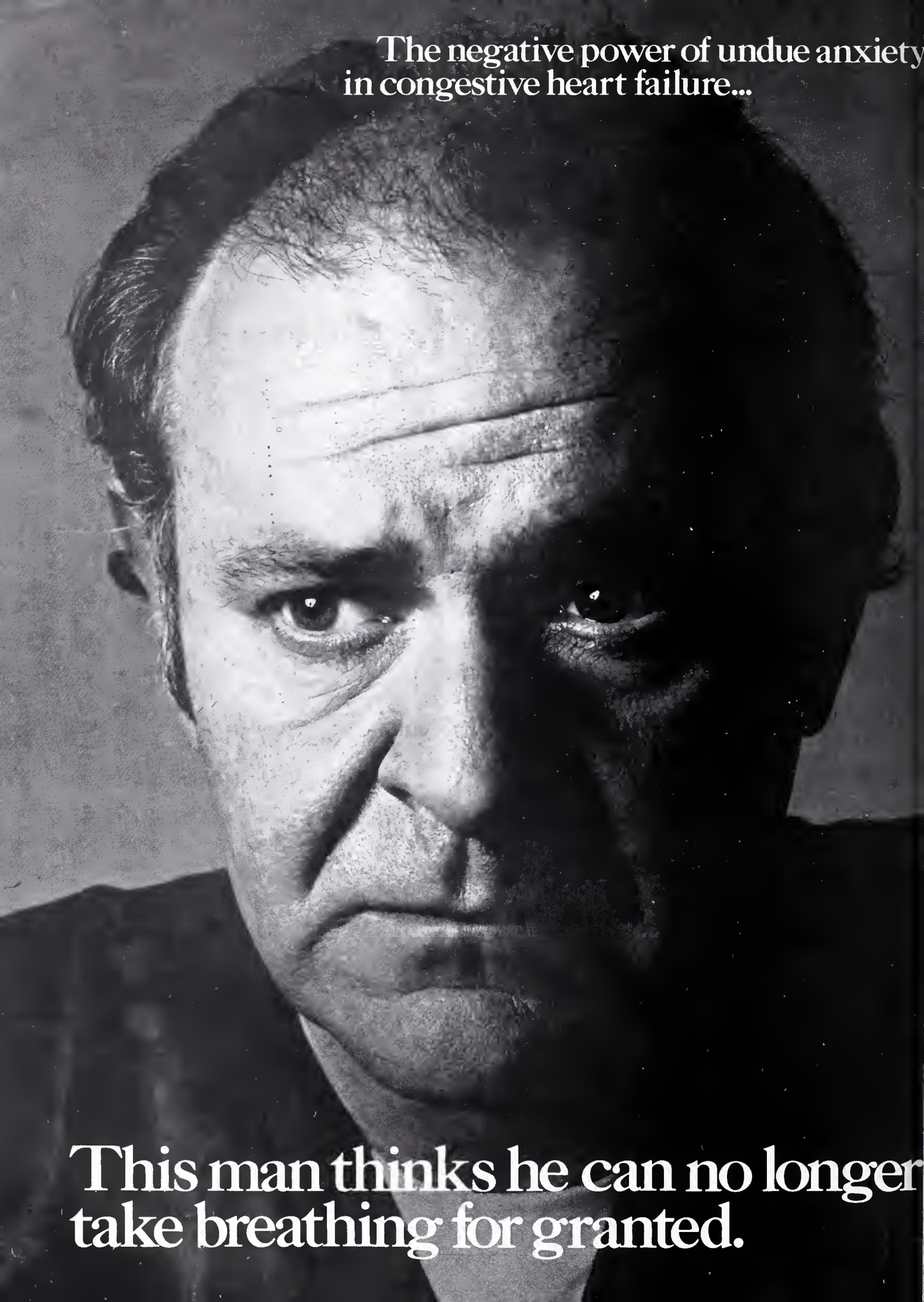
28. Pathology, sixth edition, 2 volumes, edited by W.A.D. Anderson, M.D., published by C. V. Mosby Co. 3207 Washington Blvd., St. Louis, Mo. 63103, price $29.50.

29. A Manual of Respiratory Failure, Crews and Lapuerta, published by Charles C. Thomas, Springfield, Ill.

Classified

ALASKA Medicine

Volume 14, Number 3, July 1972


The negative power of undue anxiety
in congestive heart failure...
This man thinks he can no longer
take breathing for granted.

ALASKA MEDICINE

Official Journal of the Alaska State Medical Association
Official Journal of the Alaska Dental Society

1135 Eighth Avenue, Suite 1, Anchorage, Alaska 99501

APPLICATION TO MAIL AT SECOND CLASS POSTAGE RATES IS PENDING AT ANCHORAGE, ALASKA

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LETTER TO THE EDITOR

Dear Sir,

A difficult problem in therapeutics occurs when a chronic illness becomes incurable, but the patient lingers on, perhaps in pain, perhaps senile, perhaps comatose. The physician must decide when to use heroic measures to maintain life, and when to let the patient die in comfort and dignity. Physicians sometimes allow the family to make these painful decisions, and it can be argued that often the physician is the more appropriate person to make them. In any case, the task is made easier for both if the wishes of the patient are known. One device for this purpose is a letter of instruction (not part of the will, which is not opened until after death) which has been written by the patient in happier times. One formulation of such a letter follows, and it is offered merely because it seems to me better written than some. The author is unknown.

TO MY FAMILY, MY PHYSICIAN, MY CLERGYMAN, MY LAWYER.

If the time comes when I can no longer take part in decisions for my own future, let this statement stand as the testament of my wishes:

If there is no reasonable expectation of my recovery from physical, mental or spiritual disability,

I, _____

request that I be allowed to die and not be kept alive by artificial means or heroic measures. Death is as much a reality as birth, growth, maturity and old age -- it is the one certainty. I do not fear death as much as I fear the indignity of deterioration, dependence and hopeless pain. I ask that drugs be mercifully administered to me for terminal suffering even if they hasten the moment of death.

This request is made while I am in good health and spirits. Although this document is not legally binding, you who care for me will, I hope, feel morally bound to follow its mandates. I recognize that it places a heavy burden of responsibility upon you, and it is with the intention of sharing that responsibility and of mitigating any feelings of guilt that this statement is made.

Alaska Medicine will consider for publication any original material of possible interest to our subscribers. Color or black and white photographs, slides, or negatives are acceptable. Reproductions will generally be black and white. Reprints should be ordered at the time of submission. Authors will be sent three complimentary copies of the journal in which their work appears.

ABOUT THE COVER

"San Souci"

Ruins of palace of Henri Christophe, Negro leader of northern Haiti in the early 1800's.

Warren Jones, M.D.

DONALD EDWARD TATUM, M.D.

1922 - 1972

Born 6/1/22 in Palacios, Texas. Deceased 4/10/72 in Portland, Oregon.

He received his MD degree from the University of Oregon in 1947, interned at Emanuel Hospital in Portland. He practiced for 2 years (1951-52 and 1954-55) at the Oregon State Hospital in Salem. He served in the USAF as a Captain in the Medical Corps from 1952 to 1954. From 1955 to 1958 he had a residency in Internal Medicine and served as a clinical instructor at the University of Oregon.

He came to Fairbanks to practice in 1958, practicing with the Fairbanks Clinic until 1961 at which time he joined the Tanana Valley Medical-Surgical Group and became a partner.

He left Fairbanks in July of 1965 to take a clinical fellowship in Allergies in Denver, Colorado, and in 1966 went to Portland, Oregon, to practice, specializing in Internal Medicine with a sub-specialty in allergies. He served as a clinical instructor at the University of Oregon in Internal Medicine, also.

Dr. Tatum was a man with many talents. In addition to his specialization in Internal Medicine, he had special training in OB-GYN, general surgery, and psychiatry - in any one of which he could have become a specialist.

He enjoyed hunting and fishing. He is survived by his wife and two children.

TOM EUSTACE CARTER, M.D.

1937 - 1972

Born 7/17/37 in Temple, Texas. Disappeared 2/11/72 on a plane flight to Miami - last heard from over Burwash Landing, Yukon Territory.

He was raised in Huntington, West Virginia, and took his premedical education at Marshall University in Huntington, West Virginia.

He received an MD degree from the Medical College of Virginia in 1962, interned at New England Center Hospital (Tufts) in Boston, and then took a residency in Internal Medicine at Fitzsimmons General Hospital in Denver, Colorado, from 1963 to 1966, under the U. S. Army.

Following that, he served for a year with the 24th Evacuation Hospital in Vietnam and was then transferred to Bassett Army Hospital at Fort Wainwright in Alaska where he served with the Army from 1967 to 1970.

Upon separation from the U. S. Army he went to work for the Tanana Valley Medical Surgical Group, specializing in Internal Medicine with a special emphasis on gastroenterology. He was also a consultant for electrocardiograms for the Central Peninsula General Hospital in Soldotna.

Dr. Carter was actively interested in raising Alaskan huskies, the local and state Ski Patrols, and flying. He was on a flight to Miami in his own Bellanca when last heard from over Burwash Landing. An extensive air search failed to locate him. He is survived by his mother, a brother, and 3 sons.

Prudhoe Bay

Flat land . . . studded with lakes.
Shallow lakes, sterile,
Blue in the summer
And whipped by winds
Bathed in the midnight sun,
Yielding, twinkling waves
And white-caps,
Until the fog-banks move over the land.
A body of ice in the winter,
Capped with blowing snow - -
Only a mere outline remains
When the white-outs are still.

That land clipped green in the summer
Covers the foggy Tundra
Inviting the fool-hardy
To traverse its spongy surface.
Observe the wolf,
Caribou, the fox, waterfowl,
The deadly game of survival
In this Arctic Land.

Arising from this frozen wasteland
On stilts and beds of gravel
Buildings dot and surface
While roads criss-cross the tundra,
Marking the birthplace of Prudhoe Oil Fields.
No doctor signed a birth certificate
Saying it was born.
The roustabouts, the engineers,
Carefully gave it a sense of direction.

And the earth under their labor
Gave up its centuries old secret . . .
Black gold at twelve thousand feet!
Only Christmas trees remain on the paths
To mark the feverish activity
Of days gone past.
And nature, never to be cheated,
Is going about her task
Of restoring her clipped grass finish
To the paths and roads
For she knows her right.

Only the weeds own the earth.
Weeds so necessary food for the
Wandering caribou;
Weeds for geese and duck nests,
Weeds that serve to help build homes
And to serve as food for
Many varieties of wild-life.

It is an illusion to think,
That man can destroy this land.
For nature and its mighty army
Beginning with viruses;
Ovaries of each plant and animal
Constitute an army of magnitude,
That lies beyond the capacity
Of the mortal brain
To comprehend,
All ready to heal the scars
Man makes on her surface;
Stands ready with patience
That will extend into
The milleniums if necessary . . .
To accomplish her job - - of
Retaining her given right - -
The earth belongs to the weeds.

There are those who have added
To their voice,
To a cause labeled ecology, who
Fervently yell loud and long:
Those accomplishments cannot match
The work done by one tundra blade of grass,
Or one tundra flower that
Pushes the snow away
To accomplish its own task;
Nor the worker in the field,
Who has tenderly nourished a
Motherless bird!
- -Back into the ranks of nature,
Mighty army, where man lies embedded
Burdened with the cross
Of fragility - -
Viewing the insect
On its lofty perch.

Raymond D. Evans Sr. M.D.

PRESIDENT'S PAGE

Joseph K. Johnson, M.D.

Joseph Johnson, M.D.

The first Alaska Health Congress having just concluded, we are now reflecting on its successes and failures. The financial balance sheet is not yet available, but there is little reason at this time to expect that we will not remain in the black. The Congress was certainly extravagantly praised by our out-of-state participants. The people from Washington, especially, praised it because of its innovative nature. Among our own membership a few grumbles were heard, but a certain amount of honest criticism is welcome and will be taken into consideration in planning future conventions and congresses. At this point, in time we would like to think that the first Alaska Health Congress will be followed by a 2nd and a 3rd and so on. We also think it likely that the ranks of future congresses will be swelled by the addition of other organizations such as the dentists, the pharmacists, etc.

Although the scientific portion of the congress was somewhat hidden in the fold-out page of the program, it is worthy of comment and commendation. Six excellent speakers of national and international renown provided a total hourly input equal to or exceeding that of previous annual convention scientific programs. I believe the arrangement by section is in keeping with the programs of other similar groups and that the ASMA now has a large enough membership with major specialty representation to justify it. In the future I hope to see more sub-specialties included in the program.

The large amount of input which we received on the general subject of "future medical systems" was "straight from the horse's mouth". With such authorities as Doctor Monte DuVal, Mr. Arthur Hess, Mr. Boyd Thompson, Doctor Tom Ainsworth, Doctor Fred McGinnis, and Doctor Hildegard Peplau (representing the Nursing Profession) a lot of ground was covered. The response in the discussion groups (which were a rather unique feature) clearly indicated the acute interest of all participants in this vital area. There is little doubt that legislation new pending will have a very considerable impact on our medical practice in the near future. Just how immediate this impact is depends on the outcome of such bills as HR 1 in this Congress and/or the Medicaid bill in our current, lengthy legislature. But the most important fact to emerge from these sessions is that we must involve ourselves more and more in these matters and maintain a strong position of leadership if we are to preserve our freedom to practice the same high quality of medicine for which we have been trained.

A rather chilling anecdote which was heard at the meeting in Anchorage went as follows: The Assistant Secretary for Health and Scientific Affairs, Dept. of H.E.W. was approached by a very powerful industrialist. He (the industrialist) said that it had just come to his attention that there were some problems related to health care delivery for which he had an "instant" solution. Why not do as industry did in the 1950's when faced by a shortage of engineers and physical scientists? Namely ballyhoo these fields as careers for young men and women until such a vast surplus was being ground out by Universities that they completely lost their status as professionals and management material. We now hear everyday stories of engineers, physicists, etc. who are delivering papers or checking groceries in supermarkets. With a zero population growth and a projected physician census of 450,000 in the 1980's, is it too far-fetched to think of ourselves in this situation in another decade?

You will be represented at the AMA Convention this month (June) by your delegate, as well as by your president, past-president, and executive secretary. The first Alaska Health Congress has put us in the national spotlight as health care innovators. We intend to reinforce this position in San Francisco.

COMMISSIONER'S PAGE

Frederick McGinnis
Commissioner,
Department of Health & Social Services

In this first Commissioner's Page, appreciation is expressed to your editor for inviting our comments for the readers of this magazine. Having attended the recent Health Congress, I would like to take this opportunity to congratulate the Alaska Medical Association, and in particular your Executive Director, for spearheading a first such program in the nation. It is our opinion that the getting together of the agencies which participated in this program can only stimulate the development of a better understanding of each other's problems, resulting in better services and care to the people of Alaska, which is the essence of our chosen professions.

I would like to present to you in this first article some of the new developments within the Department of Health and Social Services.

MEDICAID

The State's new Medical Assistance Program has been passed by the Legislature, and if signed by the Governor, will include part of the current General Relief Medical Program which, as you know, is an extensive medical care program offered to eligible persons by the State. In essence, the GR Medical Program makes available certain medical services required or recommended by a doctor of medicine in providing adequate care for eligible Alaska residents. The program is provided to individuals or families currently enrolled in the State's financial assistance, or welfare programs, without access to public health facilities, and to medically needy people without access to public health facilities. Under current funding arrangements this program is supported almost 100% by State monies. In recent years the rising cost of providing this program in Alaska has placed an increasing burden on the State's General Fund. In less than six years, expenditures for the program have increased from approximately *one million dollars* to over *eight million in FY 1971-1972.* In order to maintain the current level of services provided to the low income people in the State, and to control the costs to the State, a new medical assistance program has been defined which includes Medicaid, a Federally sponsored health care program.

Under this program certain medical services currently offered under the GR Medical Program will be offered under Medicaid. Specifically, these services will include: Inpatient hospital services; outpatient hospital services; laboratory and X-Ray services; skilled nursing home care; physicians services; screening, diagnosis, and treatment of children; home health services; and transportation.

The Medical Assistance Program, including both Medicaid and GR Medical, will offer substantial benefit to Alaska. Under Medicaid, the Federal Government will match, dollar for dollar, the State's cost of medical assistance to Alaska's eligible welfare recipients. *Additionally*, Federal matching monies will be *increased* for Federal-State public assistance programs from a current level of approximately 30% without Medicaid to 50% with Medicaid. The estimated cost savings to the State of Alaska's General Fund for this increased Federal matching will amount to between three and four million dollars annually, based on current rates of expenditures. The savings will not be from "Health" dollars. More "Health dollars will be expended. The savings will be developed by a more favorable federal matching formula.

Recipients eligible for the program have been categorized into three groups based on the services available to them. Group I persons are those individuals receiving financial assistance who do not have access to public health facilities. These recipients are eligible for only those services offered under Medicaid. In special situations where adequate medical services are not available at public health facilities, the Group 2 recipients may also be eligible for other than Medicaid services. Group 3 persons are individuals who are not receiving financial assistance but are indigents in need of medical care and do not have access to public health facilities. These recipients are eligible for all services offered under the Medical Assistance Program.

In summary, then, the Medical Assistance Program has been defined to satisfy three objectives:

1. Utilize available Federal Matching monies to the extent possible.
2. Maintain current level of medicaid services.
3. Reduce State medical expenditure.

Federal guidelines have been established as to how the State will administer the Medicaid Program. However, the guidelines are reasonably flexible and the Department is currently evaluating alternative methods pertaining to the

administrative and processing aspects of the program.

Generally, the system is being designed to expedite delivery of and subsequent payment for services delivered. To date, three items have been identified which will modify current administrative processes:

1. Those providers desiring to participate in the Medical Assistance Program will be requested to sign a standard contract with the State agreeing to abide by the Medicaid laws and regulations of the State. It should be noted that enrollment in the program is voluntary and providers may withdraw from the program at any time. However, participation will be encouraged by the Department.
2. In order to gather the necessary information to meet Federal reporting requirements, billing for services rendered will be submitted on a State supplied form.
3. Finally, but certainly not of insignificant importance, methods of reimbursement will be modified to comply with Federal guidelines. Although details regarding this aspect of the program are still being evaluated, providers can generally expect to be reimbursed in accordance with Federal reimbursement standards of the Title XVIII Medicare Program.

Providers representatives will be requested to serve on an Advisory Committee to help develop the "State Plan" for Medicaid.

ALCOHOLISM PROGRAM

A major new thrust of alcoholism programming is just beginning. This has been made possible by two important pieces of Federal legislation. One is the Social Security Act, Titles IV and XVI, which is not new but has had a new interpretation which allows 75% Federal funds for alcoholism programs. The other law is PL 91-616, the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act of 1970, which formed the National Institute on Alcohol Abuse and Alcoholism and which mandated Planning and allowed some Federal funds for the purpose.

The large expansion this past year of alcoholism programming is in its initial stages of implementation in Alaska. There are 25 new contracts with local governmental and private, non-profit agencies throughout the State. These contracts have starting dates from February 1, 1972 to June 1, 1972. The total contract cycle is not complete for many contracts. That is, the money for operation is not as yet available for use. Therefore, a measurement of effectiveness or impact is not feasible. When the contracts are all in force, *3 1/2 million dollars* of alcoholism programming will be emplemented. This figure represents $2,080,000 in State and Federal funds with the balance being the local participation. The goal of the State Office of Alcoholism is that the programming shall be organized in such a way that a total comprehensive social services system is available to alcoholics. This will not be possible for all areas since not all services are feasible in all areas and travel is necessary in some cases. Services will include Detoxification (usually in hospitals and not financed through the Social Security Act), Rehabilitation, Halfway House arrangements, In-patient and Outpatient Counseling, Information and Referral Services, and one Sleep-off Center.

In addition, the State of Alaska is initiating an Industrial Alcoholism program which will provide services for the employed alcoholic. The two staff members are receiving three weeks of intensive training before they begin operation. This expansion is permitted by the receipt of $50,000 from the National Institute of Alcohol Abuse and Alcoholism.

The second piece of legislation (PL 91-616), is the authority for an additional $200,000 for the State Alcoholism Program. This money has not as yet been awarded, but it is expected to be available for the program. The receipt of the money was contingent upon the preparation and submission of a State Plan for Alcoholism Programming. Of the grant, $180,000 will be spent in a thorough and valid measurement of alcoholism incidence and prevalence in Alaska plus a careful evaluation model of the million-dollar Fairbanks program in an effort to more precisely determine appropriateness of treatment.

DRUG ABUSE PROGRAM

The Department of Health and Social Services has, since the Legislature was last in session, taken the initiative to develop a coordinated approach to the rapidly growing drug abuse problem in Alaska. The following has been accomplished within available resources:

1. The Governor has designated the Department of Health and Social Services as the single state agency responsible for drug abuse programs.
2. The Council on the Administration of Justice approved the transfer of LEAA Grant Funds from the Governor's Office to this Department, ($19,000 for drug abuse education).
3. The Department negotiated a contract with the Open Door Clinic in Anchorage

to provide some counseling and referral services.

4. Action has been taken to consolidate existing drug abuse programs by transferring funds, programs and the Drug Education Specialist from the Department of Education to this Department. The following grants will be monitored in the area of drug education.
   a. Training grants for communities.
   b. Continuation of the Office of Education Grant for school and community education and prevention programs.
   c. Peer Council training.
   d. Community education grant to Fairbanks (1 or 2 such grants awarded nationwide).
5. With no state funds authorized for treatment programs, the Department actively sought Federal funding to implement such programs. A tentative commitment of $200,000 was obtained and a grant proposal was submitted which provided in part for the establishment of a chemical dependency treatment capability at API in support of the Anchorage Druge Abuse Program. To date, the Federal funding has not materialized and it appears doubtful that the grant proposal will be funded.

For the remainder of this Fiscal Year, the Department will actively seek Federal funding for the development of treatment, rehabilitative and educational programs.

The budget for Fiscal Year 1973 reflects a significant increase in drug abuse funding. A total of $370,000 is designed for drug abuse programming.

There is Federal legislation now pending which could provide from $200,000 to $250,000 of additional Federal funds under formula grant procedures.

With this budget, the Department will provide an Office of Drug Abuse which was recently provided by legislation and which will be structured along the general lines of the Office of Alcoholism. For the first year, it is expected that the Office will be staffed with a Coordinator, a Grants Management Specialist, an Education Specialist, and a Secretary. The Office will function under and be responsible to the Commissioner in order that necessary coordination may be effected between elements of the department as well as other interested departments. Legislation was enacted at the request of the department during the session just closed to establish the Office and provide for the Advisory Board on Drug Abuse. This is the initial organizational approach to the development of a comprehensive drug abuse program which will include ultimately intake and referral, treatment, rehabilitation and educational components with Federal, State and community involvement and participation.

EMERGENCY MEDICAL SERVICES

During the past several months, major efforts have been placed on organizing and implementing plans and objectives for Emergency Medical Services. Under the direction of the National Highway Traffic Safety Administration, a variety of projects are being carried out on the basis of the Highway Safety Act of 1966. Funds from the U. S. Department of Transportation serve as a catalyst for emergency services; training programs for emergency medical personnel; purchase of ambulances; and the development of communications systems.

Recently this department, upon the recommendation of the State Emergency Medical Services Committee, authorized the expenditure of Highway Safety Program funds for the purchase of nine new ambulances to be located throughout the State. Specific locations will be: Seward, Glennallen, Paxson, Haines, Cantwell, Juneau, Kodiak, Valdez, and Cooper Landing. Also in the final stages of completion is a project to provide funding assistance for radio communication equipment in the hospital. Future efforts by this department will be directed towards the development of standards for emergency medical services to include emergency vehicles, operators, drivers, attendants, communications, and emergency rooms.

MENTAL HEALTH DIRECTOR

I am pleased to announce the appointment of F. Robert Holter, M.D. as Director of the Division of Mental Health of the Alaska Department of Health and Social Services. This position has been vacant for quite some time and the department is indeed fortunate to have secured a person with Dr. Holter's abilities and experience. *It is anticipated that Dr. Holter will be reporting for duty on or about July 10.

*Dr. Holter has served in the following positions:

1. Chief of Psychiatry Services and Administrative Officer, United States Air Force, Westover Air Force Base, Massachusetts.
2. Instructor of Psychiatry and Assistant Visiting Psychiatrist, Vanderbilt University School of Medicine.
3. Founding Director of the Chester County Mental Health Clinic, Chester County, Pennsylvania and

(Continued on page 75)

DELEGATE'S REPORT
AMA CLINICAL MEETING DECEMBER, 1971

Joseph M. Ribar, M.D.

Joseph M. Ribar, M.D.

The Clinical meeting of the AMA House of Delegates was held in New Orleans from November 28 to December 1, 1971.

New Orleans is a picturesque, quaint old Southern city known for its hospitality. It lived up to its reputation and I'm sure all the participants thoroughly enjoyed the time they had away from the actual affairs of the meeting. The most curious thing to me was the lack of a Southern accent among the local people. I highly recommend it as a place to visit some day.

The meeting was rather uninspiring. The AMA headquarters were not actively picketed by protest groups as we have been in the recent past. None of the meetings of the House were interrupted by militants or activists.

Vice President Agnew appeared before a full house at the AMPAC dinner. He gave a rather lack-luster speech not highlighted by some of the wit he has become famous for. Essentially, he emphasized a better working relationship between private medicine and government. He pointed out that this has been actively sought after by the present administration. This has been made evident by the appearance of President Nixon before the AMA House of Delegates in Atlantic City last summer and the appearance of the Vice President at this meeting.

Indeed, there has been closer cooperation between the AMA representatives and the various agencies of H.E.W. dealing with health care during the past three years. Mr. Finch and now Mr. Richardson and their deputies are actually seeking advice from organized medicine for implementation of various federal health programs.

The major topic of discussion during this meeting was the recommendation of AMA President Wesley Hall, in his inaugural address at Atlantic City, that the AMA hold a constitutional convention. He avowed that this was necessary in order to modernize the executive and legislative structure of the AMA. He intimated that all was not "moonlight and roses" between the Board of Trustees and various AMA staff members, and that a power struggle is going on in the hierarchy of the American Medical Association.

This was not a popular suggestion for many in the higher eschelons of the AMA and the AMA staff. Consequently, when Doctor Hall's speech and the various resolutions and reports of the Board of Trustees were aired before Committee I, the committee recommended to the House of Delegates that no change was necessary. They felt that the mechanisms for change were already present in the present constitution and by-laws.

At this point Dr. Hall, in an unprecedented act, assumed the podium, his privilege as President of the AMA.) He again gave an impassioned plea, based on his experience during his travels this year, to try to change the structure so that the doctors at the grass roots have a better feeling of active representation by the AMA. Following this the House passed a resolution creating a Council on Long Range Planning and Development. This Council will conduct open hearings in San Francisco at the annual meeting this June.

The House acted on and passed many resolutions, of course. Of interest to Alaskans primarily were:

1) The creation of a special section on medical students and a special section on interns and residents. This will give these segments of medicine delegates to the AMA and, therefore, an active voice in AMA policy and proceedings.

2) Action to assume through its Council on Health Manpower a leadership role in developing and sponsoring a national program for certification of the assistant to the primary-care physician. And also action to develop guidelines for compensation for services of a physician's assistant.

3) The request that the AMA urge all health insurance carriers and government health financing agencies to rely on appropriate medical peer review programs for adjudication and resolution of all matters concerning quality, cost or utilization of medical services.

4) Resolved to point out to the Social Security Administration that the implementation of its present rules and regulations in regard to continued institutional care are inconsistent with good medical practice and to make every effort to publicize these matters to the American public and try to get these rules changed; i.e., retroactive denial of payments for such care.

5) Reaffirmed its stand on the validity of individual private practice of medicine as a means of providing quality care at reasonable cost, in the face of perpetual government emphasis on group practice.

6) Criticized the persistent current use by government agencies of the terms "provider" and "consumer" when the terms "physician" and "patient" are appropriate.

7) Urged that any future health programs permit direct billing and payment to patients.

8) Instructed the AMA staff to continue its efforts to develop a standard health insurance form adaptable to computers.

9) Called for active involvement of physicians in community health planning as individuals, as members of the medical society and as members of hospital medical staffs.

10) Identified alcoholism as a complex disease with biological, psychological and sociological components. Also recognized that there are multiple forms of alcoholism and that each patient should be evaluated and treated in an individualized and comprehensive manner.

All in all, 68 resolutions and 20 reports from the Board of Trustees were considered and acted upon.

We even went on record as being in favor of "women's lib" in medicine, and should recognize the woman's rightful place in medicine and medical politics.

The immediate upshot of Dr. Hall's recommendations has been a change in attitude of the Board of Trustees. They are now holding meetings in various areas of the country which can be attended by local physicians. This is a step in the right direction and in the overall picture should be good for organized medicine in the United States.

NOTICE

A computer terminal is available in Seattle (Children's Orthopedic Hospital) for direct computer service at the National Clearinghouse for Poison Control Centers in Washington, D.C., for any physician needing information on a specific poison or overdose, not available in the files of the Alaska Poision Control Centers at Anchorage, Fairbanks or Juneau. The Seattle number is 206-634-5252.

COMMISSIONER'S PAGE . . . .

(Continued from page 73)

Consultant at Coatesville, Pennsylvania Veterans Administration Hospital.

4. Director of Child Psychiatry and Medical Director for the Catholic Welfare Bureau Guidance Clinic, Trenton, New Jersey.
5. Consultant and Lecturer and Coordinator of Research and Therapeutic Services for the Developmental Center for Autistic Children, Philadelphia, Pennsylvania.
6. Clinical Associate Professor of Child Psychiatry and Pediatrics, Hahnemann Medical Center and Hospital of Philadelphia, Pennsylvania.

ALASKA STATE MEDICAL ASSOCIATION
27TH ANNUAL MEETING
FIRST ALASKA HEALTH CONGRESS

One-hundred fifty physicians, 156 nurses, 88 exhibitors, and 80 guests attended the 27th annual convention of the Alaska State Medical Association held in Anchorage, June 1, 2, and 3, 1972. During the annual banquet, Saturday, June 3, the Physician-of-the-Year, Community Service, and other awards were presented. All will remember the eulogy presented by Tom Harrison, M.D., extolling Dr. Shelton's pioneer work in ophthalmology in Alaska.

Carolyn C. Brown, M.D. of Anchorage received the A. H. Robins Community Service award for 1972. Keith Brownsberger, M.D. told of all the services that Dr. Brown had volunteered to her profession and community over the last few years since her arrival back in Alaska.

This year's convention was held in conjunction with meetings of the Alaska State Nurses' Association, Alaska State Hospital Association, American Association of Medical Assistants-Alaska Society, and Alaska Pharmaceutical Association. The three-day meeting was referred to as the 1st Alaska Health Congress and was attended by nurses, physicians, hospital administrators, medical assistants, pharmacists, and other allied health professionals from throughout the state.

Joe Bloom, M.D., Convention Chairman; Shirley Davies, R.N., Nurses' Chairman; Marion Lampman, Hospital Chairman; Mike McBain, Pharmaceutical Chairman; and Phyllis Combs, Medical Assistants' Chairman were applauded by all for their excellent performance in planning, arranging, and presenting the 1st Alaska Health Congress in a most successful manner. During the banquet, J. Ray Langdon, M.D., outgoing President, introduced new officers of the Association: Joe Johnson, M.D., President; Gary Hedges, M.D., Vice President; Glenn Crawford, M.D., President-Elect; William Compton, M.D., Secretary-Treasurer.

During the convention, the Alaska State Medical Association adopted 28 resolutions. A resume of the important resolutions is as follows.

Legislative Activities

The House of Delegates, consisting of all physician-members of the ASMA who were present;

(a) resolved that ASMA would seek a state statute abolishing the contingent fee system in Alaska.

(b) resolved that state legislation be sought which would forbid the importation or sale in Alaska of footwear having soles of any substance providing less traction on ice or snow than unpolished leather.

(c) encouraged the State Legislature to require a section for non-smokers on all scheduled airlines serving Alaska.

(d) requested the Alaska State Legislature to urge the U. S. Congress to adopt the metric system for the United States.

Medical Education and Licensure

(a) endorsed and encouraged the extension of the educational program of the Washington-Alaska-Montana-Idaho regionalization of medical and health sciences education program (WAMI) to include the entire first year of medical education in Alaska; all interested and qualified physicians were urged to participate actively in the design and implementation of clinical clerkship training programs.

(b) resolved to support all useful efforts to develop, strengthen, and/or extend continuing education for all health professionals in Alaska through the ASMA Education Committee.

(c) referred to the ASMA Medical-Legal Committee, for study, a question as to the feasibility of amending state statutes so as to equate the legal status and licensing powers of the medical and legal professions.

Medical Practice and Medical Economics

(a) approved the health insurance claim form (group or individual) incorporating attending physician's statement developed by the Health Insurance Council of HIAA and approved by the AMA's Council on Medical Service.

Communications

(a) determined to establish a committee to collect data and memorabilia pertinent to developing a "History of Medicine in Alaska."

Environmental and Public Health

(a) expressed its view that all properly qualified physicians should be granted consultant privileges, including the right to admit and treat mentally ill or intoxicated private patients (on a space-available basis) in the Alaska Psychiatric Institute, a state facility, and further encouraged all interested and qualified physicians to participate in and contribute to ongoing mental health programs at the Institute.

(b) in two separate resolutions, the House of Delegates resolved that residents of "Alaska Pioneer Homes" receive periodic examinations by opthalmologists and otolaryngologists or their assistants and receive care for eye and ear defects (including surgery and prosthetic devices), plus both admission and periodic psychiatric and physiatric examinations with care provided if found necessary.

(c) deplored closed staff privileges at Public Health Hospitals throughout Alaska and urged that hospital staff privileges be made available to all qualified physicians wishing to treat natives in those facilities, such staff membership standards to be the same as those applying to corps, civil service or contract physicians.

(d) adopted as ASMA policy recommendation that possession of small amounts of marijuana, for personal use, should be legally permitted in Alaska, at the same time firmly stating that ASMA disapproves of the use of the drug and discourages its use by all individuals.

Constitution and ByLaws

(a) amended the ByLaws to restate qualifications for Associate Membership in ASMA, a dues-exempt temporary category entitling the individual to attend all ASMA or component society meetings but not to hold office or vote. Government physicians may hold membership under this class for a maximum of three years.

(b) amended the ByLaws to permit the members-at-large of the Association to elect one Councilor to the ASMA Council; nomination shall be by poll of members-at-large and the Councilor shall serve for two years each term.

(c) amended the ByLaws regarding standing committees to provide that the State President shall poll the entire Association membership and appoint all members expressing a desire to serve on a standing committee except where the ByLaws are otherwise in conflict by specifying membership.

(d) amended the ByLaws to establish a new standing committee on Education to promote health careers, develop health careers education programs, develop postgraduate medical education programs, and establish necessary liaison with educational institutions to promote quality medical and allied health education.

Medico-Legal and Medical Ethics

(a) directed the ASMA Medico-Legal Committee to investigate the feasibility of "no fault" malpractice insurance and the feasibility of requiring each patient to insure himself against an untoward result of treatment.

Paramedical Activities

(a) resolved to seek to prohibit the practice of chiropractic in Alaska.

Management and Membership Services

(a) expressed its view that Associate Members should be encouraged to become full members of ASMA and resolved that the dues for this category should henceforth be $50 annually (raised from $35).

(b) approved a resolution to be submitted to the House of Delegates of the AMA calling for a bicameral House, more unity through increased cooperation with medical specialty societies, and a restructuring aimed at making the Board of Trustees more accessible to the membership, its actions more fully reported, and input to its deliberations more available.

Other

(a) directed establishment of a study committee to examine the relationships between the Regional Medical Program, the Comprehensive Health Planning Agency, the Alaska Advisory Committee and the Washington/Alaska Regional Advisory Committee and to recommend thereon to the ASMA Council.

(b) instructed the appropriate committee of ASMA to review the programs and policies for carrying out existing and proposed programs of the state government divisions of Public Health, and Social Services, and to make recommendations to the ASMA Council for their improvement, such recommendations to subsequently be made public if approved by the Council.

(c) banned, in future, smoking from all meeting rooms at ASMA annual meetings.

Joseph Shelton, M.D., Physician of the Year.

Carolyn C. Brown, M.D.; Keith Brownsberger, M.D.

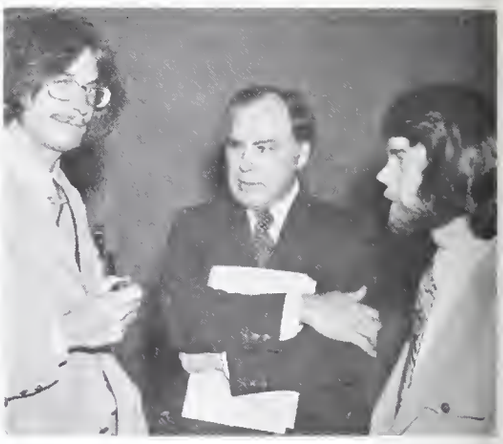
Bill Compton, M.D., Secretary-Treasurer; and Mrs. Compton.

Left to right: Gary Hedges, M.D., Vice-President; Joe Johnson, M.D., President; J. Ray Langdon, M.D., Past President; Glenn Crawford, M.D., President Elect.

CONVENTION PICTORIAL

Left to right: Richard Lyons, M.D., representing WAMI; J. Ray Langdon, M.D., outgoing ASMA President, receiving personal gavel from WAMI for his work in promoting the WAMI program in Alaska.

Left to Right: Joe Shelton, M.D., Physician of the Year; Glenn Crawford, M.D., President Elect; Tom Harrison, M.D., Anchorage Councilor - discussing Tom's leaving for a year.



Left to Right: Mike Demann, Special Assistant to the Commissioner; Dr. Fred McGinnis, Commissioner State Department of Health and Social Services; Larry Herlock, Administrative Assistant. They tell us the Commissioner just hasn't given them time to get hair cuts??

Left to Right: Arndt Von Hippel, M.D. and Joe Shelton, M.D., Physician of the Year. Aloha!

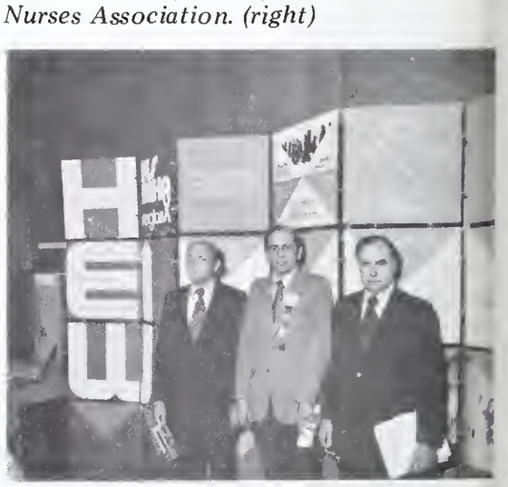
Left to right: Bert Hall, Health Congress Master of Ceremonies and Phyllis Combs, Past President of Medical Assistants.

Lucy Roberts, President of Alaska Hospital Association. (left)

Ruth Benson, R.N., President Alaska Nurses Association. (right)

Left to right: Joe Johnson, M.D., President ASMA; J. Ray Langdon, M.D., Past President. Dr. Langdon receiving his Appreciation Plaque.

Left to right: Bob Johnson, M.D., Region X HEW; J. Ray Langdon, M.D., Past President ASMA; Monte DuVal, M.D., Assistant Secretary, Health and Scientific Affairs, HEW.



Left to Right: Bruce Kelly, Director Region X, HEW; Arthur Hess, Deputy Commissioner Social Security Administration; and Dr. Fred McGinnis, Commissioner State Department of Health and Social Services.

MUKTUK MORSELS

Bob Ogden

ANCHORAGE

The 27th annual convention of the Alaska State Medical Association was held June 1, 2, and 3, 1972, in Anchorage at the Anchorage-Westward Hotel. A report of activities is included in this issue of *Alaska Medicine*.

Doctors JOHN SELDEN, TOM WOOD, and GEORGE STEWART have left The Alaska Clinic and relocated their practice of internal medicine to 207 E. Northern Lights Blvd., Anchorage, Alaska 99503.

Doctors RAY GILLS and CHARLES WALLNER have left The Alaska Clinic and relocated their practices in obstetrics and gynecology to 207 E. Northern Lights Blvd., Anchorage, Alaska 99503.

Doctor GEORGE LYON has left The Alaska Clinic and relocated his practice in neurological surgery to 207 E. Northern Lights Blvd., Anchorage, Alaska 99503.

Doctor TOM HARRISON is planning a one-year fellowship in retinal surgery in Iowa City.

Doctor MARCELL JACKSON recently had a baby girl.

Doctors TOM GREEN and PAUL DITTRICH have new sons.

Doctor GARY ARCHER is returning to practice at the Alaska Clinic July 1. Dr. Archer has recently completed a one-year fellowship in cardiology at the University of Washington.

Doctor ALLEN HENDRICKSON will begin the practice of pediatrics at the Alaska Clinic in mid July. Dr. Hendrickson is from Salt Lake City, Utah.

Doctor ROBERT BOSVELD will begin general practice at the Alaska Clinic August 1, 1972. Dr. Bosveld is currently with the U. S. Army at Fort Richardson in Anchorage.

Doctor DAVID WILLIAMS will begin the practice of ENT at the Alaska Clinic in mid-July. Dr. Williams is currently with the U. S. Public Health Service at the Anchorage Medical Center.

FAIRBANKS

Doctor ABRAM CANNON, a board certified radiologist from Chicago, will join the Fairbanks Medical and Surgical Clinic August 1, 1972. Dr. Cannon was the Chief of Radiology at Wesleyan Hospital in Chicago.

Doctor YOUNG HA, a board eligible orthopedist has been with the Fairbanks Medical and Surgical Clinic since March, 1972.

Doctor HOI EAIK LEE, a board eligible anesthesiologist from New York City, will be joining the Fairbanks Medical and Surgical Clinic in June of 1972.

Doctor SAM McCONKEY has left the Tanana Clinic to take a one-year residency in ophthalmology. Dr. McConkey plans to return to Fairbanks.

Doctor MOHAMMAD QURESHI has left Fairbanks and has joined a group of anesthesiologists in Bellevue, Washington.

Doctor JIM LUNDQUIST reports that the Tanana Clinic is still in the midst of construction and that he hopes that sometime in July the 18,000 sq.ft. of new space will be completed.

JUNEAU

Doctor PER-ARNE JOHANNSON has taken over Dr. Joe Riederer's practice for the summer. Dr. Riederer is taking the summer off to go fishing in the Fairweather grounds with his new troller.

Doctor EDWARD THOMPSON has recently entered the private practice of psychiatry. Dr. Thompson was with the State Division of Mental Health at the Juneau Mental Health Clinic.

Doctor JOHN STEPHENS has taken the summer off to return to England with his family.

Doctor GARY HEDGES reports that salmon fishing in the Juneau area is very poor this year compared to last year. (Dr. Hedges won the Golden North Salmon Derby last year and is definitely biased.)

KETCHIKAN

Doctor DICK BABCOCK has begun the private practice of obstetrics and gynecology. Dr. Babcock was a professor of obstetrics and gynecology at the University of Utah.

Doctor JACK McDOUGAL, psychiatrist, has recently begun practice in the Ketchikan Community Mental Health Center.

Doctor LOUIS SALAZAR is retiring from practice after many years of practicing in association with Dr. RALPH CARR.

PETERSBURG

Doctor PETER ROSI will soon begin practice in Petersburg. Dr. Rosi is moving to Petersburg from Sitka.

SITKA

Dr. PAUL WHITE has begun the practice of general surgery in association with Dr. GEORGE LONGENBAUGH. Dr. White was recently with the U.S.P.H.S. Hospital in Seattle.

SOLDOTNA

Doctor ROBERT G. CLAEYS has recently begun the practice of anesthesia and general practice at the Central Peninsula Clinic in Soldotna.

THREE MONTHS AT THE HOSPITAL ALBERT SCHWEITZER IN HAITI

Warren Jones, M.D.,
Anchorage

Late in 1969, my family and I visited Haiti and learned about its health needs during a 2 week visit with Drs. Warren and Gretchen Berggren who headed the Community Health Department at the Albert Schweitzer Hospital in Deschapelles, Haiti. Dr. Berggren is my wife's brother. The result of that experience was our volunteering to work June, July and August 1971 at the Albert Schweitzer Hospital. The acceptance of this plan by my two medical associates made it possible. I worked two months on the pediatric service and one month on the medical service. My wife and our three daughters and one son, ranging in age from 15 to 8 years, assisted in record keeping work at the Community Health Department.

THE COUNTRY

Haiti is a mountainous, tropical country located on the eastern one-third of the island of Hispaniola about 100 miles east of Cuba. It has a area of about 10,000 square miles and an estimated population of 5,000,000 people, mostly Negro descendents of West African slaves imported to the island in the 16th and 17th centuries by the Spanish and French colonizers. The eastern two-thirds of the island is the Dominican Republic. The mountains of Haiti have been stripped of most of the trees over the years and the wood has been used for fuel with no replanting being done. Consequently there is a large soil erosion problem with rapid run-off of water and topsoil. The valleys, however, are fertile but the agricultural methods are primitive. The Albert Schweitzer Hospital is located near the village of Deschapelles which is in the fertile Artibonite river valley of central Haiti. This location is about 20 miles from the sea and reached by about a 90 mile bumpy ride from the capital city of Port-au-Prince. The temperatures are in the 70° to 90° range most of the year, and in the summer months the heat is briefly dissipated by late afternoon rain showers.

HISTORY

The island of Hispaniola was discovered in 1492 by Christopher Columbus who reported the presence of the peaceful Arawak Indians. During the Spanish colonization of the islands, these Indians were nearly exterminated, and within

Fortress of Henri Christophe near Cap Haitien, Haiti built to defend against Napoleon.

about twenty years after Columbus arrived, few of them remained. In the late 1600's following Spain's defeat in Europe, the western 1/3 of the island was ceded to the French who named the territory Haiti and initiated a period of remarkable economic development. They exported sugar, coffee, cocoa and other products to Europe to such an extent that at this time its annual exports to Europe were said to be greater than that of the thirteen American colonies then developing. This prosperity was brought about on the colonial estates by the use of West African Negro slave laborers who had been imported first by the Spaniards and later by the French to replace the exterminated Indians. The harsh treatment that these slaves received caused them to hate their masters, and when news of the French Revolution in the late 1700's reached Haiti, the Negro slaves began a rebellion. These revolts were crushed until Toussaint L'Ouverature became leader of the Negroes and in 1801 defeated the French, seizing control of Haiti. In 1802 General Leclerc, the husband of Napoleon's sister Pauline, arrived with a large force of French army veterans from Egypt and attempted to retake the islands which Napoleon dreamed of using as a base to invade Louisiana and to seize land in North America. The Negroes retreated to the hills and burned the towns and villages behind them and began guerilla warfare.

The Fertile Artibonite Valley

The Mountains of Haiti

The French were not used to this type of fighting and many of the troops died from yellow fever. Finally, yellow fever also claimed the life of General Leclerc and the remaining French troops left the island. On January 1, 1804, Haiti proclaimed its independence. Since that time it has been a republic but it has never regained the prosperity enjoyed under its French rulership. During the reign of Negro leader Henri Christophe, who controlled the northern half of Haiti from 1806 to 1820, the country enjoyed some of its former prosperity but following his death economic decline set in and has continued to the present day. Christophe has been succeeded by a number of presidents who have ruled by support of military power. United States aid has been given to the country several times in this century, but because of political difficulties has been withdrawn. The Haitian government does little to support the masses of the citizenry. In fact, at the present time the people of Haiti are probably the poorest of all inhabitants of the Caribbean islands.

THE HOSPITAL ALBERT SCHWEITZER

The Hospital Albert Schweitzer was founded in 1956 by Dr. and Mrs. Larrimore Mellon. He is related to Andrew W. Mellon, at one time Secretary of the Treasury of the United States under Presidents Harding, Coolidge and Hoover. In his early years Dr. Mellon worked in the family business concerns and with Gulf Oil Co. and was a rancher as well as an undercover agent during World War II in Europe. He became acquainted with the work of Dr. Albert Schweitzer in Africa and was greatly inspired by this man and his imagination. In his 40's he gave up his ranch in

The Denuded Mountains

Arizona and entered Tulane Medical School, New Orleans, where his wife studied laboratory technology. While in training they sought a place where they could build a hospital in an area which had great needs both medically and economically and chose the Artibonite Valley of Haiti. The hospital is located on the site of a former fruit plantation near the village of Deschapelles. It is a

Hospital Albert Schweitzer

The typical peasant home.

one story building with two large main wings and an out-patient department arranged in a series of examining rooms around a beautiful central court area which has breadfruit trees, a pool and rock garden in it. The hospital has approximately 150 beds and is well equipped with excellent x-ray, laboratory and pharmacy facilities.

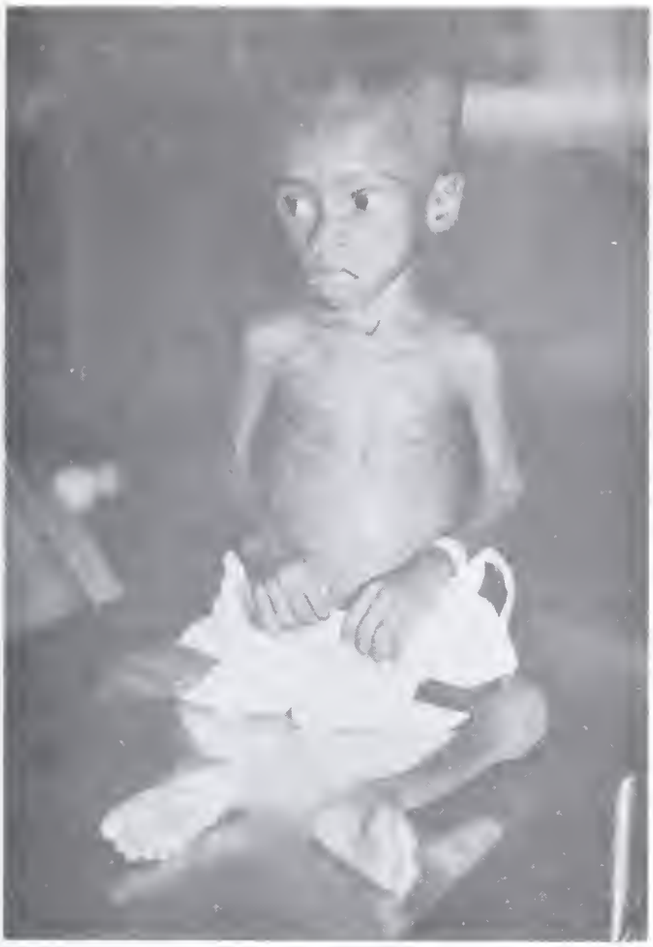
The doctors and other members of the staff live with their families in comfortable homes surrounding the hospital. There were about twelve doctors with the facility when I was there, of whom four were Haitian. Almost all the physicians and nurses serve short terms of from a few weeks up to about two years. They represent different national and religious backgrounds such as Mennonites from Canada, Protestant nurses from Holland, Catholic nuns from Europe and Canada, and other Caucasians without religious affiliations. A New York City pediatrician was the director of the three doctor pediatric service. She spends a year at the Albert Schweitzer Hospital, alternating with a year in her private practice in New York City while her pediatric associates do likewise. The other pediatric physician was a resident from the University of Alabama and later a teaching pediatric neurologist from Pittsburgh. For periods of several weeks during the summer orthopedists and ophthalmologists, mainly from the eastern seaboard states, worked at the hospital.

WORK AT THE HOSPITAL

The people of the Artibonite Valley, like all the Negro peasants in Haiti, are very poor and frequently under-nourished. They live in mud and thatched huts about 8' x 10' in size with a dirt floor. Even where a family owns a tiny plot of land, the soil is often poor and the methods of cultivation are so primitive that few of the people live above subsistence level. Due to the lack of food supply, they raise few animals. Almost all the food is consumed by the people and consists mainly of grain crops of corn, rice, beans and millet.

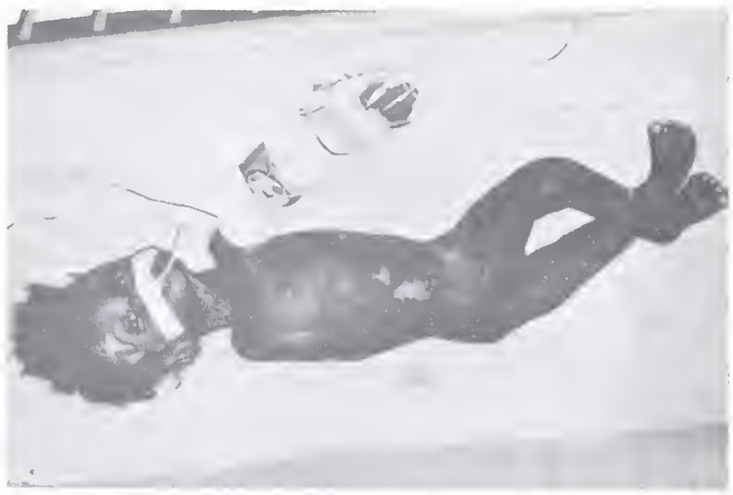
The Community Health Department of the hospital emphasizes nutrition education in nutrition centers at various villages up and down the valley. The classes consist of twenty to twenty-five poorly nourished children, several parent cooks, and the teachers who stay during the daytime and return to their homes at night. The peasants are taught the essentials of adequate child nutrition based on available Haitian grain foods and at a cost that they can usually afford of about 9¢ a day for each child. The children stay three months in the nutrition center and the parents spend several days each week helping and learning. Beans are the main protein source of their diets; and corn, rice, millet, some fresh fruits and vegetables and an occasional egg or small bit of meat are the remainder.

There are few cows for milk, and store bought powdered milk is too expensive for most Haitians. Most of the people are illiterate and education in feeding must be very simple. The parents of all hospitalized malnourished children are required to receive this training. The value of this training becomes apparent after one sees the children with severe malnutrition and kwashiorkor. Numerous young children with kwashiorkor were brought to the hospital looking like little old men and women with somber, sad faces, rusty reddish-brown hair and swollen bellies, legs and genitalia. At times the skin begins to slough and open skin sores develop



Haitian infant with marasmus and sickle-cell anemia.

which are ready areas for entry of infection. These children are apathetic and pathetic, but with improved nutrition many of them exhibit remarkable changes over a period of several weeks. So many infants and young children are seen in the clinic suffering from malnutrition that it is impossible to admit all who need care. Those with the most severe disease are admitted for immediate treatment, some dying from concurrent infection. Others who do not look so ill are given powdered milk reinforced with carbohydrate, a grain cereal, medicine for intestinal parasites, parenteral vitamin A and penicillin. They usually return in a week and as beds become available, are admitted for further care. The care of malnutrition in the acute phase usually lasts for a week to 10 days and consists of feeding the children whole milk every 3 to 4 hours which is gavaged if they are unable to take it orally. Lack of vitamin A causes a striking eye disease in some of the children called keratomalacia, which sometimes results in perforation of the cornea and prolapse of the iris. Malnutrition diseases are not usually seen in children under 2 years of age because of the habit of nursing the children for 18 months to 2 years following which they must largely subsist without milk. At the weaning stage, diarrhea may develop and this in association with malnutrition is frequently a fatal combination for these children.



A starving child too weak to eat.

The usual malnourished child stays in the hospital one month, the last three weeks being in the convalescent ward where the children have less intense medical supervision and are eating usual Haitian foods. With improved nutrition the brown or red skin pigments and the gray or red hair change to the dark black of health and a normal kinky hair configuration. Kwashiorkor varies with the season of the year and is less when a good bean harvest is available but becomes increased again at bean planting season.

Tetanus of the newborn is common but less than in previous years because of an immunization campaign against tetanus for pregnant women and better education of peasants and midwives. Large scale immunization programs against tetanus are carried out in the market places around the valley and at various villages. All the deliveries are attended by mid-wives. By custom and tradition many of the attendants at birth put charcoal or animal dung on the end of the cord, which is the source of neonatal tetanus. The mid-wives are given kits with a sterile razor blade and string to allow them to tie the cord, but many of the peasants from the mountains will walk for hours or even all day with a newborn baby to have the cord cut and severed in a cleanly manner in the hospital. Usually the placenta is still attached to the baby. The babies are given tetanus antitoxin. Over the last several years, ther has been a notable decline in the number of hospital admissions for neonatal tetanus, a disease that formerly killed up to 90% of affected babies admitted to the hospital. Now about half these infants are surviving due to improved management.

Tuberculosis is widespread and afflicts many of the children as well as the adults. Sputum specimens are collected from the peasants in areas in which they live and brought back to the hospital for screening for acid fast bacilli with fluorescent staining techniques. Up to a dozen persons may live in a typical, small, peasant home and the habit

Happy Children

Food time at nutrition center.

of closing all the windows at night to keep out the evil spirits increases the spread of tuberculosis and respiratory infections. Isoniazid, thiacetazone and para-amino-salacylic acid are being used primarily to combat tuberculosis. Dr. Frank Lepreau, director of the hospital, capably performs thoracic surgical treatment for T.B. Near the hospital is a living area for tubercular patients to keep them on drugs and improve their nutrition until they are suitable for surgery if this is indicated. They also convalesce in this area after surgery. This has helped considerably in the care of these patients who previously went home to re-infect their families.

The patients arrive at the hospital by foot, on horse or donkey, or by camion which is an open air bus. Monday, Wednesday and Friday are the very busy out-patient days. Many patients arrive after one or two days journey and sleep overnight on the steps of the hospital. The day begins about 6:00 a.m. with registering of the patients in the well kept record area, and patients are seen until about 6:00 or 7:00 in the evening. The staff regularly breaks for about fifteen minutes each mid-morning and mid-afternoon and about one hour at noon while the patients wait patiently. The hospital has two modern, well-equipped surgical rooms, an efficient x-ray facility and laboratory area, and a modern medical library, all of which are air conditioned. It is a pleasure to be in those areas on a hot day if it can be arranged since the remainder of the hospital is not cooled. The x-rays are performed by Haitian technicians and are of excellent quality. A radiologist is in attendance periodically to read difficult films and weekly x-ray conferences are held for the doctors to review interesting films and cases with one another. The laboratory is directed by American volunteers and a large volume of bacteriology and parasitology is done. Pharmaceutical products are bought at low prices or donated by service organizations, and the pharmacy was managed by a capable young man trained, not in pharmacy, but the clergy, who also conducted religious services. The Pediatric Ward was usually filled with about sixty or seventy acutely ill infants and children.

A World Health Organization sponsored project to eradicate malaria has been going on in Haiti for a number of years but the problem has not been eliminated. We would see several cases of malaria each week, usually in children. A young man in his 30's died of cerebral malaria in the hospital in the summer of 1971. Blood cultures are done frequently for febrile patients to diagnose typhoid fever. This dramatic disease which I had not seen before proved fatal in some of the

children. These children typically had high fever and a toxic appearance but most responded well to large doses of chloramphenicol. Gastroenteritis with moderate to severe dehydration was so common that many of these children could not be admitted to the hospital. They were treated overnight at the out-patient clinic and frequently at the end of the day from a half dozen to a dozen children would be lying on stretchers in the clinic receiving intravenous fluids for the night. Many of them would recover sufficiently after one to two days to return home. Respiratory infections and pneumonias in the children were common and usually responded to penicillin. The Haitians have a variety of anemias related to malnutrition as well as the hereditary sickle-cell anemia common to the Negro races. Many of the sickle-cell patients required blood transfusions, and many of them having a shortened life span, as a result of their disease. Parasitic diseases are ubiquitous due to the lack of adequate sanitation. I autopsied one six-year old child with severe kwashiorkor in whom I found perforation of the transverse colon due to ascaris boring through the wall. Some of the large round worms up to 6" long were free in the peritoneal cavity and the resulting peritonitis was the immediate case of the child's death. Acute osteomyelitis was occasionally seen in children and sometimes presented a differential diagnostic problem. The pain in an extremity could be mistaken for trauma of soft tissues in light of negative x-ray findings and late appearing x-rays changes in bone of acute infection. I recall one infant whom I sent home with minimal treatment who returned to the clinic approximately a week later with a fulminant meningitis from which it died. Children with meningitis and sepsis were admitted frequently.

On the Medical Service I saw adults with malnutrition, hypertension, cardiomyopathies, and various infectious diseases, usually some form of tuberculosis, including tuberculous pericarditis. Leprosy is not common in the area, but I saw one patient with it. Some of the adults presented with diabetes mellitus and peptic ulcer disease but I did not see patients with obesity or alcoholism. Occasionally patients with advanced cancer and venereal diseases were seen in the clinic.

COMMUNITY PROJECT

Dr. and Mrs. Mellon in their early years in Haiti spent most of their time in the hospital, but as more dependable help became available they have broadened interests and have spent much of their time outside the hospital, particularly Dr. Mellon, who is seen there only occasionally now. He is more frequently found in the villages in the valley helping the peasants with various farming and irrigation projects and community development projects. Improvement in agricultural methods is one of the most obvious needs of this depressed country. A full time Haitian agriculturist trained in the United States oversees the livestock production program of the hospital which consists of a large beef cattle farm, a Holstein dairy herd which produces milk for the hospital need, a swine raising area, and a poultry house. The peasants are encouraged to take cows on loan to feed and to care for the calves that are born and are paid market price by the hospital for the beef they produce from these animals.

One of the great problems in Haiti has been the unequal distribution of rainfall in the country with long periods in the winter months without rain. Most of the rain falls in the summer and consequently there are long periods of drought during the dry season of December through April. In the early 1960's an attempt was made to improve this situation and an irrigation project was started with the help of American money in the Artibonite Valley. This scheme was called the Organization for Development of the Valley of the Artibonite, abbreviated ODVA. Unfortunately, the United States support for ODVA was withdrawn before the system was completed, but some canals were built in the valley which have been helpful in irrigating the land. Presently Dr. Mellon has been active trying to continue the good work started by this project and has helped the peasants develop wells and pipe water from hills to village centers. One recent project is a new road into the mountains beyond the Artibonite valley some 20 miles from the Hospital, which is to allow the peasants easier access to market and to the villages of the valley. The peasants contribute to the cost of these projects with labor and actively participate in the road development and pipeline projects.

Cotton spinning has been developed to encourage the economy of these people. Cotton grows well in many places and the peasants are encouraged to pick it and spin it. The products are then bought by a buyer from the peasants and the material collected in the hospital shop where it is woven and dyed into various cloths, bedspreads, rugs and cushions, some of which are exported.

The carpentry shop trains people in manufacture of furniture from local woods which resemble mahogany and walnut. It is hoped this project will encourage some of these people to start their own business. Pottery training is also available in the hospital area and many of these pottery items are sold at reasonable prices with the maker receiving part of the purchase price and part of it going into the shop to expand the project.

So far, the hospital has not been involved to any large extent in the primary education of the people toward literacy. This is a great need if any

A Haitian senior citizen.

advance is to occur. Presently, families pay money to send their children to elementary school, and less than one-fourth of the children receive elementary education. Hopefully the government will make efforts to increase the literacy rate of the people.

CONCLUSIONS

The medical needs of this underdeveloped, underprivileged country are staggering. If any permanent improvement is to be made in the health and welfare of this population, sanitary, nutritional and educational standards must be raised. The medical center of the Albert Schweitzer Hospital has become a base for community development projects whose value over the long run will be greater than that of the hospital itself.

From this short experience, my family and I wondered if our work was to have any long range value. The problems of these peoples frequently seemed overwhelming and insoluble. I think we helped somewhat, but the greater value of the experience for us was a better understanding and appreciation of the needs of the underprivileged peoples of the world. Our cultural myopia was refocused from affluence to an awareness of how many of the people in our world live. The burdens of these Haitians have tried them hard and have left a lasting impression on our minds. The need for short term service continues at the Albert Schweitzer Hospital. Hopefully, other volunteers will also reap the benefits of such encounters with the underprivileged peoples of the world.

Sunset at the Beach

AURORA DENTATUS

R. A. Smithson, D.D.S.

Convention Notes

The 1972 Annual Meeting of the Alaska Dental Society at Mt. McKinley Park was a great success. It was well attended, approximately 100 Dentists registered, half of which were from out of state. Dr. Art Hansen and his lovely wife, Debbie put it together and ran the entire event virtually by themselves.

President-Elect Dr. Craig Kauffman, ably conducted the business meetings of the Society in the absence of President George Fraley who is putting in a hitch on the S. S. HOPE. The passing of the gavel ceremony was brief. Newly elected officers were Arnold Pflugrad, President-Elect; Curt Menard, Secretary; Bob Sutherlin, Treasurer; Robert Horschover, Delegate; and Aubrey Stevens, Alternate Delegate.

Clinician Bob Nara provided stimulating, innovative concepts for today's G. P. in Dentistry. He left his mark, and we will be seeing applications of the Nara methods in Alaskan offices.

Dr. Clayton Polley was elected to Life Membership in the Alaska Dental Society. He is a Founding member and was the second President. Clayton is retiring from Dentistry after forty-three years of practice to some serious gardening at their Lena Point home.

Dr. Norm Riddell was absent from the convention - he and Ernie Dunn (plus spouses) were taking Norm's boat to Seattle where he hopes to aquire another more suited to his needs.

Dr. Bob Horschover is outfitting his boat with a Dental office to be able to serve some of the Southeastern towns accessible only by float plane or boat and without a resident Dentist.

Dr. Wally Connell recently renovated the lower level of his home into a fine office.

Dr. Walt Babula has established his office in Fairbanks for the practice of Orthodontics.

The otherwise informative, happy professional gathering was marred by the news of passage of the Medicaid Bill by the Alaskan Legislature. Dr. Josh Wright, (D. House of Rep.) commented on the inane actions of Alaska's legislature and the ultimate (and prolonged) insult to the producing tax-payers of the state. What a sorry session! How long can we, as *productive* Alaskans tolerate these thieves and leeches? Dentistry has long been the last bulwark against Governmental encroachment. Has it crumbled, and is there no recourse, no common sense - has our professional integrity been lost to the expedience of political thievery? Make no mistake, Doctor, today's political (*both elected and appointed*) powers are not working on your behalf, but their own. There certainly are exceptions, but the professional politicians outnumber the non-professionals, and too often these men are not only our enemies, but downright thieves. They are responsible for inflation, the cruelest tax of all, and now the prostitution of a truly great profession, as well as a great and costly disservice to the taxpaying constituents.

The membership of the Kenai-Kodiak Area Dental Society cordially invites all members of the Alaska Dental Society to attend its quarterly clinical sessions.

On September 1-3, Dr. James McGraw of the University of Washington, Department of Endodontics, will be the clinician for the fall meeting to be held at the office of Dr. I. Blake McKinley in Kodiak.

In November, Dr. Edward Miller of Bethel will present a follow-up program to his May 6th clinic on occlusal trauma and its relationship to periodontal disease.

Information regarding associate memberships in the Kenai-Kodiak Area Dental Society and/or assessments for its meetings may be obtained by contacting Dr. Warren W. Huss, Box 717, Seward, 99664.

PRINCE WILLIAM SOUND BY SAIL

Arthur Geuss, D.D.S. (skipper)
Liz Geuss (crew)

At a recent dental meeting, several of us were commenting on the varied and interesting adventures in which many of the members of our Alaska dental group took part. Bob Smithson then asked if my wife and I had another sailing trip planned this summer and in reminiscing about our July 1970 trip, I agreed to recount its highlights for *Alaska Medicine.*

About four years ago when my wife and I first took the ferry from Whittier to Valdez across Prince Williams Sound, we thought, "What a magnificent place to cruise in a sail boat" and immediately started planning. Without a large sail boat of the cruising class available, we decided it could be done in our little 13-foot International FJ dingy. The FJ is a fast, sporty, little racing craft with its main, jib, and spinnaker sails having 175 sq. feet. We could day sail with four adults in the open cockpit, but I doubt if anyone would even consider using it for the purpose we had in mind. However, Liz and I had raced and sailed in Japan, the Carribbean and lower "48", so we had plenty of experience to draw on.

Discussion of the trip led to the discovery that while the trip had been made in power boats and kayaks, there was no record of the trip ever having been made by sail; certainly, not solo in a 13-foot open dingy. The basic concept established, we tried to organize several boats to sail together for greater safety and in July of 1969, we launched our first attempt from Whittier. As often happens with such plans, our accompanying boats all failed to show. Liz and I weren't yet up to the idea of solo, so we cruised the Passage Canal and the Port Wells area for a week. Our equipment and gear proved to be quite adequate and we decided next year we would go for sure.

The following year we arrived in Whittier on July 4th with two larger boats that were to accompany us, a 20-ft. Balboa and a 21-st. Cal. Both were cabin cruising boats that sleep four. So with high hopes, we launched in the afternoon in a bad rain storm with increasingly strong winds. After a wild attempt to beat upwind out to Shotgun Cove, it became just too rough and we returned to Entry cove at the edge of Whittier for our first night.

Liz and I beached our boat in the cove and camped under our 12' square plastic tarp. Jim and Nancy Lethcoe moored their Cal 21 at the mouth of the cove, as did Nancy and Chuck Simmerman with Rudi Schmidt aboard their Balboa.

Dr. Arthur Geuss and wife Liz aboard their FJ

The wind and rain howled all night and into the morning on Sunday. Arising, we discovered that the Balboa had its rubber dingy torn off and lost in the storm. Then they discovered that their motor wouldn't run. The Lethcoes in the Cal 21 were suffering from inadequate rain gear, so we all returned to Whittier at noon.

After a long conference, Liz and I decided to try it alone when the others decided that they couldn't attempt the trip at this time. About 1:00 PM we again launched into the rain and the by now light wind. Liz and I were well prepared, wearing full floation suits against the dangers of being dumped and exposure. We also had our gear and food well organized in water tight plastic bags, separated into individual bags for each meal and secured aboard in netting. The sleeping bags were similarly packaged in water proof bags. Our gear took up the back one half of our open cockpit and weighed about 150 lbs., leaving us fairly light and

with the normal portion of our cockpit for the skipper and crew open.

We covered about 14 miles in seven hours and camped on a lovely beach in Surprise Cove just outside the south edge of Passage Canal. It cleared and we built a fire on the beach to dry everything out. In fact, we just pitched our plastic tarp and rolled the sleeping bags out under it on the beach.

The next day, we awoke to more low clouds and no wind. After a late start, we slowly made our way over to the north end of Culross Isl. Abruptly, it cleared and a stiff breeze sent us sailing across to Esther Isl. under spinnaker. We really roared along the rocky shore, keeping close to stay out of the higher winds and seas. We had to dodge fishing boats and nets for several miles just off the rocks as the fishing fleet was in working the south edge of Esther Island. We got lots of astonished, but not too friendly, looks from the fishermen. Undoubtedly, they were probably figuring we would run through their nets, which we didn't. Our spirits soared with the sunshine and good winds. About 7:00 PM we pulled into a cove on the north shore and got some fresh water. The bugs were so bad we went on another half mile to a rocky point to fix dinner. There, in a breeze, we ate in comfort while our little boat feathered down wind off the rocks.

At 8:00 PM we decided to go on across the next bay to the old site of Knicklick to camp. Arriving about 10:00 PM, a short investigation showed little of interest, so back aboard for another two hours to Olsons Island and its lovely little deserted cabin. The 10:00 PM to midnight cruise was especially rewarding, with a rainbow out in the sound and good close looks at many seals on the rocks and around the boat. The trip by sail made you constantly aware of every sound on the sea, since we had no motor noise to spoil it, or to scare the seals and other marine life. This was to be our longest day with 11 hours sailing and 31 miles.

Olsons Island had once been the home of some Scandanavian fisherman and his family. The little pink house with white trim and picket fence and wall paper inside reminded you of New England. It must have once been a happy spot, however it was now in decay. The water was like air, it was so clear and many colors of bright starfish dotted the ocean floor. We were constantly amazed by the many colorful starfish and the variety of jellyfish we saw.

Late that morning the wind died enough for us to slip off the lee of the island into the sunny windswept bay. We beat across to Fairmont Island, up the back side, around Granite Point and across the channel to Irish Cove on Glacier Island.

That evening it clouded up abruptly and started to rain by 8:00 PM. We had a nice hot supper and turned in early.

Wednesday morning, there was no wind, heavy fog and mist, so we explored Glacier Island. There were meadows filled with wild flowers; we found hundreds of chocolate lilies, some with double blossoms. We also explored the remains of the old gold mining operation there. There were several buildings and cabins with relics of the old operation.

Finally, a late noon start sent us drifting up the shore and across to the mainland. In mid-channel we had a real thrill as a killer whale blew and surfaced only 20 feet away. Liz was really excited and I turned us away as two or three dozen whales started rolling on all sides. WHAT A SIGHT!

We also started encountering our first ice bergs and had a time dodging them in Columbia Bay in the poor light as we crossed to Heather Isl. to camp in a little cove about a mile or so from the face of the Columbia Glacier.

While pitching our plastic tarp to set our tent under, we were invaded by two hummingbirds. They must have thought Liz in her orange suit and me in my yellow, to have been giant flowers. They would fly through our plastic cover and land only a couple of feet away.

The glacier was very active that night, producing the frequent thunder of ice falls and some large swells running into our cove from the ice. If only the bad weather had lifted, we would have stayed for another few days. However, it seemed even worse Thursday, and we rode the tide to Elf Point, Cape Freemantle and on into the mouth of Valdez Arm. There we also saw many seals, porpoise and another school of whales out in the arm. A light breeze allowed us to run before it towards the narrows. As we reached the mouth of Sawmill Bay the wind really picked up, and we hoisted our Spi to go on a wild planing ride through the narrows and on into Valdez, covering the last 14 miles in less than two hours. We dropped the spi off at the small boat harbor and sailed up to the Wyatt House dock. We caused quite a stir in the bar when we sailed in. After a week in the rain and cold with only 24 hours break, we really took great delight in our hot baths, steak dinner and champagne celebration.

On Saturday we borrowed a trailer to haul the boat aboard the ferry and retraced our trip to Whittier. Enroute back we spotted the two big boats that were to accompany us. They had come after all and duplicated our "first" a week later. Our solo voyage in the little FJ will always be more special to us, I'm sure.

Dr. Geuss is one of Anchorage's sailing enthusiasts and is Past Commodore of The Alaska Sailing Club.

MIDDLE EAR DISEASE FROM EUSTACHIAN TUBE MALFUNCTION

Lee A. Harker, M.D.*

Because of its high incidence in the native population, middle ear disease has received much attention in Alaska.[1-9] It exists in different forms. (Table 1) Suppurative otitis media is seen in acute and chronic forms. Acute suppurative otitis media occurs most commonly in infants and young children after an upper respiratory infection and is a bacterial infection of the middle ear space which may or may not result in spontaneous tympanic membrane perforation. Chronic suppurative otitis media occurs either as a cholesteatoma or as an established tympanic membrane perforation. There also occur different types of middle ear disease which occur as a result of malfunction of the eustachian tube. These forms are common in both native and non-native children because eustachian tube malfunction is a common problem of childhood. In a recent three month survey of a Mt. Edgecumbe grade school, 15% of 109 kindergarten through 4th grade children required surgical treatment for middle ear effects of chronic eustachian tube malfunction.[10] Impedance audiometry screening of the entire populations of several schools, preschools, Head Start Programs, and nursery schools in Southeast Alaska revealed that one-third of the 761 ears tested exhibited failure of eustachian tube function at the time of the test.[11] This paper will discuss three types of middle ear effects, serous middle ear effusion (serous otitis media), middle ear atelectasis, and secretory middle ear effusion (secretory otitis media). They are presented as distinct entities and while most cases are readily divisible into these groups, a continuum of middle ear disease from eustachian tube malfunction probably exists. Several characteristics of the normal anatomy and physiology of the eustachian tube and middle ear serve as a foundation for the discussion.

The middle ear is connected to the nasopharynx by the eustachian tube and is dependent upon the function of the latter for its well-being. The eustachian tube is normally closed with the walls of its lower cartilagenous portion and isthmus held in apposition by the capillary forces of the apposing mucous membranes, the resilience of its walls, the pressure of adjacent

TABLE I

I. SUPPURATIVE MIDDLE EAR DISEASE
   - A. Acute Suppurative Otitis Media
   - B. Chronic Suppurative Otitis Media
     1. with established perforation
     2. with cholesteatoma

II. NON-SUPPURATIVE MIDDLE EAR DISEASE
   - A. Serous Middle Ear Effusion (Serous Otitis Media)
   - B. Middle Ear Atelectasis
   - C. Secretory Middle Ear Effusion (Secretory Otitis Media)

structures, and the tonus of the tubal muscles (Tensor palati, Levator palati and Salpingopharyngeus). The tube's primary function is to equalize the middle ear pressure with the near atmospheric pressure of the nasopharynx; this occurs during swallowing. This equalization of pressure is necessary because the air in the middle ear is constantly being absorbed by epithelial capillaries, thus lowering atmospheric pressure there. This equalization occurs very briefly during swallowing as the Tensor palati opens the eustachian tube. Yawning and performing the Valsalva maneuver may do the same.

The epithelium of the eustachian tube is a continuation of that of the upper respiratory tract with pseudo-stratified ciliated columnar cells and mucus-forming goblet cells normally present. The lamina propria, in addition to a basement membrane and a lymphoid layer which is most prominent at the pharyngeal end, has a glandular layer which contains muco-serous glands. Progressing up the eustachian tube through the middle ear to the mastoid antrum, the pseudo-stratified epithelium gradually gives way to columnar and even single-layered cuboidal or squamous epithelium. Normally cilia may be present as far posteriorly as the mastoid, and goblet cells may be seen on the promontory of the middle ear.[12] This entire epithelium has the capability of differentiating more toward a mucus-producing respiratory surface or a keratin-producing squamous surface, depending upon the local environment.[13] The epithelium produces a thin blanket of mucus which is propelled by ciliary action and gravity from the tympanum to the eustachian tube and to the

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pharynx. The mucus empties into the nasopharynx when the tube is closed as well as during the brief open periods.

SEROUS MIDDLE EAR EFFUSION

If the eustachian tube fails to open for a period of time, it is said to be locked; air continues to be absorbed from the tympanum but it is no longer replenished. This absorption of air leads to a negative intratympanic pressure which may reach -500 mm. of water relative to atmospheric pressure. If the middle ear is free of infection and inflammation a thin, watery transudate collects as a result of this relative negative pressure. The partial vacuum causes capillary damage with disruption of the basement membrane and epithelium, resulting in leakage of serum proteins and occasionally cells. Tissue edema occurs and the sub-epithelial space may be widened 5-10 times. Initially there is little or no inflammatory component but if the condition persists for months, round cell infiltration is often seen in the edematous lining. There is no increase in the mucus-secreting elements of the epithelium; the effusion is not a secretion but a transudation of serum which it resembles in color and protein content.[14-15]

Experimentally, serous effusion is readily reproduced in dogs, cats, and monkeys by simple eustachian tube obstruction. Negative middle ear pressure and serous fluid result as long as the method employed does not invoke inflammation or infection in the middle ear. The pressure drop is evident in minutes to hours and reaches its maximum in roughly a day; the effusion developes in from one to four days.[16-19]

Clinically, this same result may be seen from a variety of causes. The eustachian tube may fail to open because of mucosal abnormalities such as thickening or scarring, dysfunction of the Tensor palati, or extrinsic pressure upon the tube. Examples of these are respectively: respiratory mucosal allergy (either inhalant or food), Gasserian ganglion neurectomy for the relief of tic douloureux with inadvertant damage to the motor division of the trigeminal nerve, and nasopharyngeal tumors. Some of the more frequent causes of eustachian tube malfunction, for example, viral upper respiratory infection and adenoid hyperplasia, may be accompanied by significant infection or inflammation in the middle ear space. Only if they are not will the resultant fluid be serous.

Symptomatically, the disease is unimpressive. It occurs most commonly in children who are often unaware of any symptoms. Ear pain is most uncommon. A sensation of fullness or pressure in the ear is often noticed but the patient may not be aware of any hearing loss. On physical examination, clues to the etiology of the eustachian tube malfunction may be evident in the nasopharynx. Examination of the tympanic membrane usually reveals the following features: 1 an amber hue, 2. retraction with a prominent short process of malleus, 3. decreased mobility during pneumatic massage, and 4. a chalky, white handle of malleus. Sometimes curved, dark lines which move with pneumatic massage are visible through the tympanic membrane. They represent air-fluid interfaces and indicate that some air is present there as well as the serous fluid. This appearance is diagnostic of serous otitis media but without it, tympanic membrane retraction and decreased mobility are the most helpful signs.

Audiologic testing usually reveals a mild conductive hearing loss. This rarely exceeds 30-35 decibels, and there is no impairment in speech discrimination. The hearing loss results both from the negative pressure in the middle ear space and from the presence of fluid. Experimentally, a conductive hearing loss exists both when there is negative middle ear pressure before fluid has formed, and when fluid is instilled into the tympanum without any decrease in air pressure.[20-21]

The clinical course of the disease depends entirely upon the cause. If the eustachian tube function resumes within a short time as it usually does in patients with barotrauma,* or with hayfever after ragweed season is over, any fluid is evacuated down the eustachian tube by gravity and ciliary action, and some of it is probably absorbed by pinocytotic action of the mucosa.[15,22] The middle ear then reverts to normal. If, however, the negative pressure persists, adverse effects may occur. Most noticeable is a loss of the normal structure and resilience of the tympanic membrane. This primarily is due to a loss of its middle fibrous layer and may represent a destruction of existing fibers, a lack of their reconstitution in the normal process of cellular

*Aero-otitis is an acute form of the same problem which results from the inability of the eustachian tube to equalize a rapidly increasing atmospheric pressure. During the ascent of an airplane, middle ear pressure increases relative to the decreasing atmospheric pressure. This pressure gradient is dissipated because the eustachian tube acts as a one-way valve and is passively opened by high middle ear pressure. After the middle ear has been acclimated to the reduced pressure of high altitude, the pressure on both sides of the tympanic membrane is equal. During rapid descent the pressure gradient is in the opposite direction with atmospheric pressure exceeding that of the middle ear. Only active opening of the eustachian tube can equalize this and it may become locked if the pressure change is too rapid. With an upper respiratory infection the gradient which can lock the eustachian tube is much less than normal. A serous effusion will result if the partial vacuum persists. Ear pain may be marked because the process is acute. An analogous situation exists in barotrauma from underwater diving.

turnover, or both. The result is a thin, flaccid tympanic membrane which becomes progressively more and more retracted by the longstanding negative pressure until, in severe cases, its undersurface contacts the bony medial wall of the middle ear. It may become adherent in some areas -- adhesive otitis media. In the posterior-superior quadrant, as the tympanic membrane becomes progressively retracted, it rests upon the region where the incus articulates with the stapes. Even without suppurative episodes, the long and lenticular processes of the incus may be gradually eroded, completely separating the incus from the stapes. This ossicular discontinuity apparently occurs by avascular necrosis and may result in a further decrease in hearing. It is possible that cholesteatoma may arise from longstanding serous effusion, but probably it occurs much more commonly secondary to secretory effusion.

Treatment of serous otitis media is usually successful. If there is a specific cause such as nasopharyngeal tumor or allergy, specific treatment is indicated. If not, general conservative measures such as the use of antihistamines, vasoconstrictors or a combination in conjunction with the Valsalva maneuver and the passage of time are usually effective. The relative importance of each of these measures is not known since the disease is characterized by spontaneous remission and since it is sometimes difficult to distinguish serous effusion from other forms. Although most cases resolve with this type of treatment, refractory cases present a problem. Even though the causes of serous effusion reside in the nasopharynx and eustachian tube and it is the effects which are seen in the middle ear, this is one situation when surgical treatment is often best directed at the effects.

Operative procedures on the eustachian tube have been notoriously unsuccessful in restoring its function. In fact, they have sometimes turned a temporary malfunction into a permanent obstruction because of postoperative scarring. Similar effects have resulted occasionally from adenoidectomy, the role of which deserves further comment. A large obstructive adenoid mass filling the nasopharynx can obviously obstruct the eustachian tube orifice and any otolaryngologist would recommend removal as part of the treatment. On the other hand, the role of adenoidectomy for non-obstructive adenoid tissue and the role of repeat adenoidectomy are not as clearly defined. The same (poorly understood) factors which stimulate the growth of adenoidal tissue also affect similar tissue in the lymphoid layer of the pharyngeal and of the eustachian tube; hypertrophy there can also give rise to eustachian tube obstruction and malfunction. This tissue is not accessible to adenoidectomy and vigorous attempts to remove it are almost certain to cause cicatricial obstruction. It is quite possible that the restoration of function following adenoidectomy is often unrelated to the operation, but merely reflects the fact that the child is older. In a longitudinal study of a large group of cleft palate patients, who are known to have a very high incidence of eustachian tube malfunction and ear disease, there was a linear decrease in the percentage of children exhibiting eustachian tube malfunction as age advanced. There was no statistically significant difference between those who had undergone adenoidectomy and those who had not.[23] It is probable that the same situation exists in non-cleft palate patients although a similar study has not, as yet, been completed.

It is for these reasons that refractory cases should have myringotomy, with the placement of an indwelling ventilating tube in order to evacuate the middle ear fluid and abolish the negative pressure. If the eustachian tube malfunction is permanent, permanent artificial ventilation is necessary.

MIDDLE EAR ATELECTASIS

In some cases, negative pressure exists in the middle ear chronically in the absence of fluid. It seems unlikely that this merely represents a first-stage of serous effusion. It is not known whether the magnitude of the negative pressure is less in these cases, whether the capillaries of these individuals are more resistant to negative pressure, or whether fluid previously present has been eliminated while eustachian tube malfunction persists. Regardless, certain differences are apparent between the two types. With middle ear atelectasis the entire tympanic membrane loses its fibrous elements and becomes atrophic and retracted. Frequently, it becomes layered over the entire medial wall of the tympanum outlining tympanic topography. Symptoms are little different from serous effusion with one exception. These patients are frequently able to autoinflate their ears by the Valsalva maneuver but refuse to do so because it causes pain. This is much less noticeable in patients with serous or secretory effusion. Also, there is frequently pain following myringotomy in these patients and not in the others. The mechanism underlying this is not clear. Ventilating tubes have a greater tendency to come out early because the flaccid tympanic membrane does not hold them in place as well, but if ventilation is maintained and there are no adhesions present, the tympanic membrane usually begins to return to its normal position and even, with time, acquires more substance and stiffness. Complications and treatment are similar to those of serous effusion.

SECRETORY MIDDLE EAR EFFUSION

If the eustachian tube malfunction is accompanied by a chronically irritated middle ear mucosa, thick mucoid fluid is produced in the sub-atmospheric pressure of the hypoxic middle ear space. Biopsies of the middle ear mucosa at the time of myringotomy for secretory effusion show the surface epithelium to contain an increased number of mucus-producing cells, and in places the surface may appear simply as a sheet of goblet cells. Impressive also is the increase in size and number of subepithelial mucus glands.[13] It is from the proliferation of these elements that the excess mucus is produced, although it may also contain epithelial debris and bacteria from a previous acute suppurative infection. Electron microscopic studies provide further evidence in support of this concept that the majority of the mucous effusion is produced by the proliferation of mucus-forming elements.[15]

Symptomatically, secretory middle ear effusion is similar to serous effusion. Ear pain, if present, is mild. Due to the chronicity of the condition, the patient is well-adapted to his symptoms and often considers them to be a part of his normal state. Frequently, there is a history of previous attacks of acute suppurative otitis media and, in fact, these two disorders each predispose to the other. An acute suppurative episode provides an intense inflammatory stimulus which can transform the mucosa of the middle ear to the predominantly secretory state; if the eustachian tube fails to function the other prerequisite is met for production of mucoid effusion. When chronic secretory otitis media follows on the heels of an episode of acute suppurative otitis media, viable bacteria are frequently present in the tenacious fluid and, in fact, a smoldering infection is present. The natural defense mechanisms of the middle ear, dependent upon an aerated middle ear space with normal epithelium and muco-ciliary flow, are already severely compromised, and any further insult such as an upper respiratory infection may lead to recrudescence of the acute suppurative process.

Examination with the pneumatic otoscope often reveals total immobility of the tympanic membrane.

Secretory effusion is much more difficult to treat successfully than serous. The thick, mucoid glue, once present, is not easily eliminated, partly because it is being continuously secreted. The proliferation of the goblet cells also means that there are proportionately fewer ciliated cells to propel it down the eustachian tube and into the pharynx. Its higher viscosity also impairs clearance.

As with serous effusion, any specific underlying diseases or problems should be treated. Frequently, these patients are children with chronic, purulent rhinorrhea and the underlying cause may be respiratory mucosal allergy, immunologic deficiency states, bacterial sinusitis, chronic suppurative adenoiditis, or a combination of these. These causes of infection and inflammation in the nose, nasopharynx and eustachian tube must be appropriately medically or surgically treated. Additionally, however, treatment must be directed to the ear. The biggest therapeutic advance of recent years was the introduction of the transmyringeal ventilating tube by Beverly Armstrong in 1954.[24] After myringotomy and aspiration of the thick fluid, the indwelling tube allows the middle ear space to remain aerated. The purpose of the tube is not to provide drainage for the fluid, but to provide a normal atmospheric pressure and oxygen tension for the middle ear so its mucosa and defense mechanisms can return to normal. Even though ventilating tubes usually remain in place a few months, they may need replacement several times before this is achieved. Again, the passage of time is probably an important factor. The complications of secretory effusion include those of serous effusion--conductive hearing loss, tympanic membrane damage, ossicular discontinuity, adhesive otitis media, and cholesteatoma formation--as well as the predisposition to acute suppurative otitis media. The conductive hearing loss may be greater than that of serous effusion, sometimes reaching a 50-60 decibel air bone gap. On other occasions the hearing remains within the normal range. The development of a cholesteatoma from this process probably requires many months or a few years, but once it has formed, complications including total sensorineural hearing loss, acute suppurative labyrinthitis, facial paralysis, sigmoid sinus thrombosis, petrous apicitis, meningitis and brain abscess, are possible. It is for the prevention of complications that treatment is indicated even in the presence of normal hearing.

GENERAL COMMENTS

Both diagnosis and treatment of these patients present real problems to the physician. The most important facet of diagnosis is ascertaining whether the eustachian tube is functioning adequately. Judgement of tympanic membrane mobility by use of a pneumatic otoscope is the most reliable means of doing this. Several types of pneumatic otoscopes are available (Fig. 1) but the use of one is essential. Alternate compression and rarefaction of the air in the external auditory canal, sealed at one end by the otoscope and at the other by an intact tympanic membrane, cause a to-and-fro motion of the

Figure 1.

tympanic membrane in an aerated middle ear. With experience this normal motion can be differentiated from the decreased or absent mobility of the fluid containing tympanum. Inspection of the eardrum without pneumatic testing in inadequate. Distinguishing serous or secretory effusion from adhesive otitis media may not be possible without myringotomy and, in fact, they may co-exist, with parts of the tympanic membrane adherent to the promontory of the middle ear and fluid present elsewhere in the tympanum. Diagnostic myringotomy may be necessary to distinguish the serous from the secretory effusion as well. Tympanometry and measurement of acoustic impedance by means of the electro-acoustic impedance audiometer may well provide a more accurate means of diagnosis, but as yet data is insufficient. A recent review describes this instrument and early experiences with its use in Southeast Alaska.

The therapeutic dilemma is when to switch from medical to surgical treatment of the ear in those cases where specific measures directed at the nasopharynx and upper respiratory tract fail to resolve the problem or are not applicable. In middle ear atelectasis or serous middle ear effusion, if improvement is not evident after four weeks of medical treatment, an otolaryngologic referral is indicated. Secretory middle ear effusion, once established, is a surgical disease. Again, tympanometry is proving to be an excellent objective means of judging the results of treatment. Serial testing clearly shows whether eustachian tube function is improving or worsening. Unfortunately, the electro-acoustic impedance audiometer is expensive and its availability is limited. When it becomes more available and more experience has been gained with its use, the evaluation and treatment of eustachian tube problems in Alaska will be easier.

SUMMARY

1. Serous middle ear effusion is a condition in which a transudate of low viscosity serous fluid forms in an uninflamed middle ear space, secondary to prolonged eustachian tube malfunction.

2. Middle ear atelectasis is a similar condition in which prolonged failure of eustachian tube function causes air to be absorbed from middle ear. Serous fluid is not present, either having not been formed, or having been absorbed as an earlier stage in the process.

3. Secretory middle ear effusion is a condition in which a high viscosity mucoid fluid is secreted by a proliferation of middle ear mucus-forming elements in response to middle ear inflammation or infection and prolonged eustachian tube malfunction.

4. These forms of non-suppurative middle ear disease are common in Alaska natives and non-natives alike.

5. Adverse results of these conditions include, a. conductive hearing loss, b. tympanic membrane distortion and deformation, c. ossicular discontinuity, d. adhesive otitis, e. cholesteatoma formation, and f. a predisposition to acute suppurative otitis media.

6. Diagnosis of these forms of non-suppurative ear disease is more difficult than that of suppurative otitis media because of the frequent lack of symptoms and an unimpressive physical examination.

7. The single most important part of the physical examination is the assessment of tympanic membrane mobility by pneumatic otoscope.

8. Impedance audiometry, where available, is a new and more accurate method of diagnosis of the underlying eustachian tube malfunction and an objective means of assessing response to treatment.

9. Treatment should progress from medical to surgical if quick response is not noted.

10. In the opinion of the author, these conditions should receive more attention in Alaska than they have.

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UTERINE BLEEDING FOLLOWING INSERTION OF TWO IUD'S:

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Complications from the intra-uterine device have been listed as pregnancy, extrusion, excessive bleeding, perforation and infection[3]. When the nylon strings of the intra-uterine device (I.U.D.) are not seen extending from the cervical os - three possibilities exist: Expulsion of the I.U.D., perforation of the uterus by the I.U.D., or retraction of the tails into the uterine cavity.

Perforation of the uterus by the I.U.D. has been well established[1,4]. Cases have been reported where a second I.U.D. was placed after the first I.U.D. had perforated the uterus[2,5]. In these cases the I.U.D.'s were uneventfully removed surgically from the abdominal cavity. The complications of insertion of a second I.U.D. with the first I.U.D. in normal position in the uterus are reported here.

CASE REPORTS

Case 1 - A 23 y.o. gravida 4, para 4, abortion 0, Athapascan Indian female had a routine pelvic examination in a village field clinic. The tails of her I.U.D. * were not seen and an I.U.D. was inserted. Nine days later she developed vaginal bleeding using up to one box of sanitary napkins a day. After five days of heavy bleeding and cramps, she came to the hospital. Her second I.U.D. was removed, revealing the strings of the original device. This I.U.D. was also removed. Hematocrit was 29%. A prior hematocrit of 39% was taken one year earlier immediately post partum. She returned home asymptomatic taking birth control pills. Three months later, she elected to have an I.U.D. reinserted and has had no subsequent problems.

Case 2 - A 40 y.o. gravida 12, para 10, abortion 2, Athapascan Indian had an I.U.D. inserted when the strings of her original I.U.D. were not seen during routine pelvic examination. She noted watery, blood tinged vaginal discharge fourteen days which stopped for two days. She then began bleeding heavily with clot formation and was seen eight days later, when this did not stop. Hematocrit was 36%. Hematocrit two years earlier was 41%. Both I.U.D.'s were removed and she has been asymptomatic for six months on birth control pills.

Case 3 - A 39 y.o. gravida 9, para 8, abortion 1, Athapascan Indian had an I.U.D. inserted when the strings of the first were not noted. She came to the hospital three months later complaining of persistent vaginal bleeding and cramps. Her hematocrit had dropped from 39% to 34% during this interval. The removal of this I.U.D. again exposed the strings of the original I.U.D. which was likewise easily removed.

*All I.U.D.'s used were Lippes Loops - sizes C and D.

DISCUSSION

It is obvious that uterine sounding and/or x-rays of the pelvis will generally locate an I.U.D. within the uterus. Because hospital and x-ray facilities were 70 to 200 air miles away, the authors felt that two I.U.D.'s would be less harmful than a new pregnancy or attempting uterine sounding under some field clinic conditions. We found that this was not the case. The patients came to the hospital for control of uterine bleeding and cramps 14, 20 and 90 days following insertion of the second I.U.D. We are no longer inserting I.U.D's under these circumstances. This report is given to document the complications that arise when two I.U.D's are in place simultaneously within the uterine cavity.

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(See comment next page)

COMMENT ON TWINNING OF IUD'S*

As the authors state, when the nylon strings of an IUD disappear following insertion, four possibilities exist: expulsion of the IUD, perforation of the uterus, retraction of the strings into the uterine cavity, or pregnancy.

It is generally accepted that the first step in managing the disappearance of the strings is a KUB x-ray. If the IUD is not seen, it is reasonable to assume that expulsion has occured. If the IUD is seen, it is necessary to rule out pregnancy, and once this is done, to ascertain whether the IUD is in the uterus or not, either by hysterography or by uterine sounding.

Due to remote location, the authors tried to forego the need for x-ray in these patients. They simply inserted another IUD. I disagree strongly with this. They did not rule out pregnancy or uterine perforation before repeating the IUD insertion. Apparently they did not sound the uteri prior to inserting an IUD, and I feel that this should usually be done to help prevent perforation with the IUD. Also, all the modern IUD's have been carefully designed to fit the uterine cavity with minimal distortion and pressure areas. They simply were not designed to occupy a uterus in pairs. Therefore, it is not at all surprising that bleeding problems developed when two IUD's were placed in the uterus.

I feel that the authors rationale for handling the disappearance of IUD strings was ill-advised, as they do, but for the above reasons in addition to the bleeding problems. - - William C. Compton, M.D.

*See page 95

MIDDLE EAR DISEASE . . . .

(Continued from page 94)

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NORTHERN HIGHLIGHTS

MUMPS ON ST. PAUL ISLAND:

Maynard, J.E.; Shramek, G.; Noble, G.R.; Deinhardt, F.; Clark, P.: Use of attenuated live mumps virus vaccine during a "virgin soil" epidemic on St. Paul Island, Alaska. *Amer. J. Epidem.* 92:301-306, 1970.

This paper describes an attempt to abort a mumps epidemic on St. Paul Island by the use of live mumps vaccine. The authors are with the Arctic Health Research Center, The Ecological Investigations Program of CDC, and the University of Illinois Medical Center.

Prior to the epidemic, which began in December 1967, mumps had not occurred on the Island within the memory of the residents. Of the 315 persons living on the Island, pre-epidemic sera were available from 195, 88% of which showed no neutralizing antibody against mumps at a dilution of 1:4. The majority of those who had received killed mumps vaccine in 1965, also showed no evidence of neutralizing antibody and no protection against the development of disease.

A total of 83 cases of mumps occurred during the epidemic. On January 5, 150 resident volunteers received live attenuated mumps vaccine. No cases of mumps appeared in the vaccinated group more than 32 days after immunization, whereas cases continued to appear in the unvaccinated group four weeks longer.

The overall infection rate was 59% for those who did not receive live vaccine, whereas the clinical illness rate was 35%. The ratio of illness to infection declined noticeably with increasing age.

For those who did receive the vaccine, the overall seroconversion rate was 82% and the illness rate 32%.

In previous epidemics of mumps on Alaskan islands (St. Lawrence in 1957 and St. George in 1965), a much higher infection rate was demonstrated than in the present outbreak. It is postulated that the vaccination of a large number of the population during the epidemic may have caused development of "herd immunity" by reducing the pool of susceptibles.

ESKIMO HEALTH - AN HISTORICAL VIEW:

Fortuine, R.: The health of the Eskimos, as portrayed in the earliest written accounts. *Bull. Hist. Med.* 45:97-114, 1971.

This paper is a detailed survey of the earliest writings by explorers, missionaries, and traders concerning the health of the Eskimos at the time of their initial contact with the outside world. The study covers the period from Martin Frobisher's first voyage in 1576 to John Murdock's account of his sojourn at Barrow in 1881-83. Many of the source materials were written by physicians serving as surgeons or naturalists on the various voyages of exploration to Canada, Alaska, or Greenland, particularly during the early and mid portions of the 19th century. The author, by the way, is with the Alaska Native Medical Center in Anchorage.

The early accounts are remarkably consistent in their descriptions of health conditions, considering the fact that most writers make only brief and incidental reference to health in describing the Eskimos. Most observers noted the people to be generally healthy, well-fed, or even fat. Their teeth were white, straight, and free of decay, although often worn down. Many writers from the earliest days remarked on the frequency of nose bleeds among the Eskimos. Everyone had a theory to explain the condition, few of which ring true. Sore eyes, due either to snow blindness, smoky houses, or possibly PKC, at least in later years, was also a prominent disability. Many Eskimos were deformed, crippled, or maimed, sometimes due to injury, other times apparently on a congenital bases. Despite myths to the contrary, the people seemed to make special efforts to care for these unfortunate victims, who must have been a drag on their limited resources.

The evidence on infectious diseases is more difficult to interpret. The Eskimos had their own burdens of infectious disease, particularly skin infections and parasitic infestations with lice and helminths. No doubt respiratory diseases and gastroenteritis were also common. The explorers, whalers, and traders, however, brought with them viruses and bacteria to which the people had no experience and hence no immunity and several terrible epidemics resulted, notably of smallpox, influenza, measles, and whooping cough. Tuberculosis was probably also introduced inadvertently by Europeans, with the devastating results known to all.

OTITIS MEDIA IN ESKIMOS - THREE VIEWS:

Maynard, J.E.; Fleshman, J.K.; Tschopp, C.F.: Otitis Media in Alaskan Eskimo children. Prospective evaluation of chemoprophylaxis. *J.A.M.A.* 219:597-599, 1972.

This paper reports a one-year double-blind trial of oral ampicillin given to Eskimo infants and children to prevent otitis media. The study took place in six villages in the lower Kuskokwim - Yukon area and was jointly sponsored by the Arctic Health Research Center and the Alaska Area Native Health Service.

A total of 173 children under seven were given an appropriate daily dose of reconstituted anhydrous ampicillin for one year. A control group of 191 children received a placebo. Study children and their controls were similar with respect to a baseline otolaryngological examination, previous history of tonsillectomy, adenoidectomy, and previous history of otitis media. The medications were administered by the community health aide or parents and usage evaluated monthly by research nurses from AHRC.

During the trial year the authors found no statistically significant reduction in acute respiratory disease between the two groups. However, the children in the ampicillin group had an attack rate for otitis media of 42 episodes/100 child years compared with a rate of 79 for the control group, a difference which was indeed significant. The efficiency of the ampicillin prophylaxis was calculated to be 47%. There was some evidence that those who took the medications more faithfully had an increased protection.

The authors do not recommend general acceptance of this regimen although they feel it might warrant consideration in a very high risk group such as the Eskimos of Alaska.

Reinhard, K.R.; Huntley, B.E.; Becker, R.S.; Philip, R.N.; Jackson, H.: Bacteriological studies on exudative otitis media occurring in six communities of Alaskan Natives. *Acta Oto-laryngologica* Suppl. 260, pp. 1-36, Uppsala, 1970.

In 1957-59, the Alaska Department of Health carried out a study of ear disease in six Native communities in the Bethel area. This program, known as the McGrath Project, attempted to assess the effect of aggressive case-finding, vigorous therapy and intensive health education on the reduction of ear disease and its sequelae. Now, more than

10 years later, the bacteriological findings from this study have been published in great detail. The principal author, formerly with the Arctic Health Research Center, is now with the Health Programs Systems Center of the IHS at Tucson, Arizona.

The study aimed to elucidate the organisms responsible for otitis media, to demonstrate what agents were associated with long-standing ear infection, and what effects if any, antibiotic therapy or prophylaxis might have on the flora. Detailed information was available on 130 individuals, 118 of them under 15 years of age. Fifty-two percent of these had developed suppurative otitis media by the age of 2. More than 40 species of bacteria, belonging to 18 genera, were recovered from the draining ears. Most were also commonly found in the pharynx in this population. Once chronic drainage was established, the microbiological agents recovered were heterogeneous, multiple and changing, necessitating regular testing for antibiotic sensitivity in order to ensure proper treatment. Geographical factors did not seem to be important in the ecology of the microbiological agents.

The authors conclude that the unusual prevalence of chronic middle ear disease in Alaska Natives is not adequately explained on the basis of poor living conditions, anatomy, or the high incidence of predisposing respiratory disease and that further study of this disabling disease is warranted.

Schaefer, O.: Otitis media and bottle-feeding. An epidemiological study of infant feeding habits and incidence of recurrent and chronic middle ear disease in Canadian Eskimos. *Can. J. Public Health* 62:478-489, 1971.

The author discusses at length the general problem of otitis media in Eskimo populations while describing his personal observations on the adverse effect of urbanization and bottle feeding on the prevalence of this disease in the Canadian Arctic. He is with the Northern Medical Research Unit at the Charles Camsell Hospital in Edmonton, Alberta.

This paper is an analysis of the otologic findings and infant feeding histories of 536 Eskimos randomly selected from five regions of the Canadian Arctic. An inverse relation is shown between the incidence of chronic middle ear disease and the duration of breast feeding. Those who were breast fed for over one year had the lowest incidence, while those started on the bottle in the first month had an extremely high rate of disease. An association was also shown between the rate of bottle-feeding and the degree of "urbanization" of the Eskimo families.

The mechanism for these findings, which deserve further study and confirmation, may be related to protective antibodies in the mother's milk or possibly provocative factors in cow's milk, according to the author.

HEALTH AT MT. EDGECUMBE SCHOOL:

Dieter, R.A., Jr.; Slater, S.; Wilson, F.; Williams, H.; Dieter, B.: The Alaskan Native teenager: his health in a boarding school. *Military Medicine* 135:1038-1042, 1970

A generation of Alaska native students has attended the BIA boarding school at Mt. Edgecumbe, near Sitka. This paper describes their health status and the health services available to them during an academic year, based on records of the PHS School Health Center and Hospital there. The principal author is now with the Stritch School of Medicine (Loyola) in Hines, Illinois.

The school enrollment was 670 Alaska Natives, ranging in age from 12.5 to 23 years. They came from 131 communities in the state, with a particularly large contingent (61) from Barrow. The group was 53% Eskimo, 18% Aleut, 15% Athabascan, and the remainder Tlingits or Haida.

The students made a total of 8518 visits to the clinic, including 2704 to the school physician, and 3038 visits to the dental clinic. All students were given an initial physical examination, routine laboratory tests and needed immunizations.

A disease survey revealed that 59% of the students had refractive errors (20/40 or worse), 38% had perforated ear drums, 24% had anemia (Hct. less than 37%) and 23% had a "functional heart murmur." Only 11.5% of the students had a negative 2nd strength PPD. Eight students were treated for tuberculosis during the year, including one case of tuberculous meningitis diagnosed the day of admission to school. Dental caries averaged 11 per student. Among acute conditions, pharyngitis and skin infections were particularly common.

Mental and adjustment problems were not discussed here except to say that a multidicipline group met regularly to assist the students and that a psychiatrist was available for consultation.

-- Robert Fortuine, M.D.

ALASKA Medicine

Volume 14,
Number 4,
October 1972

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Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed; drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.

Dosage: Individualize for maximum beneficial effect. *Adults:* Tension, anxiety and psychoneurotic states, 2 to 10 mg b.i.d. to q.i.d.; alcoholism, 10 mg t.i.d. or q.i.d. in first 24 hours, then 5 mg t.i.d. or q.i.d. as needed; adjunctively in skeletal muscle spasm, 2 to 10 mg t.i.d. or q.i.d.; adjunctively in convulsive disorders, 2 to 10 mg b.i.d. to q.i.d. *Geriatric or debilitated patients:* 2 to 2½ mg, 1 or 2 times daily initially, increasing as needed and tolerated. (See Precautions.) *Children:* 1 to 2½ mg t.i.d. or q.i.d. initially, increasing as needed and tolerated (not for use under 6 months).

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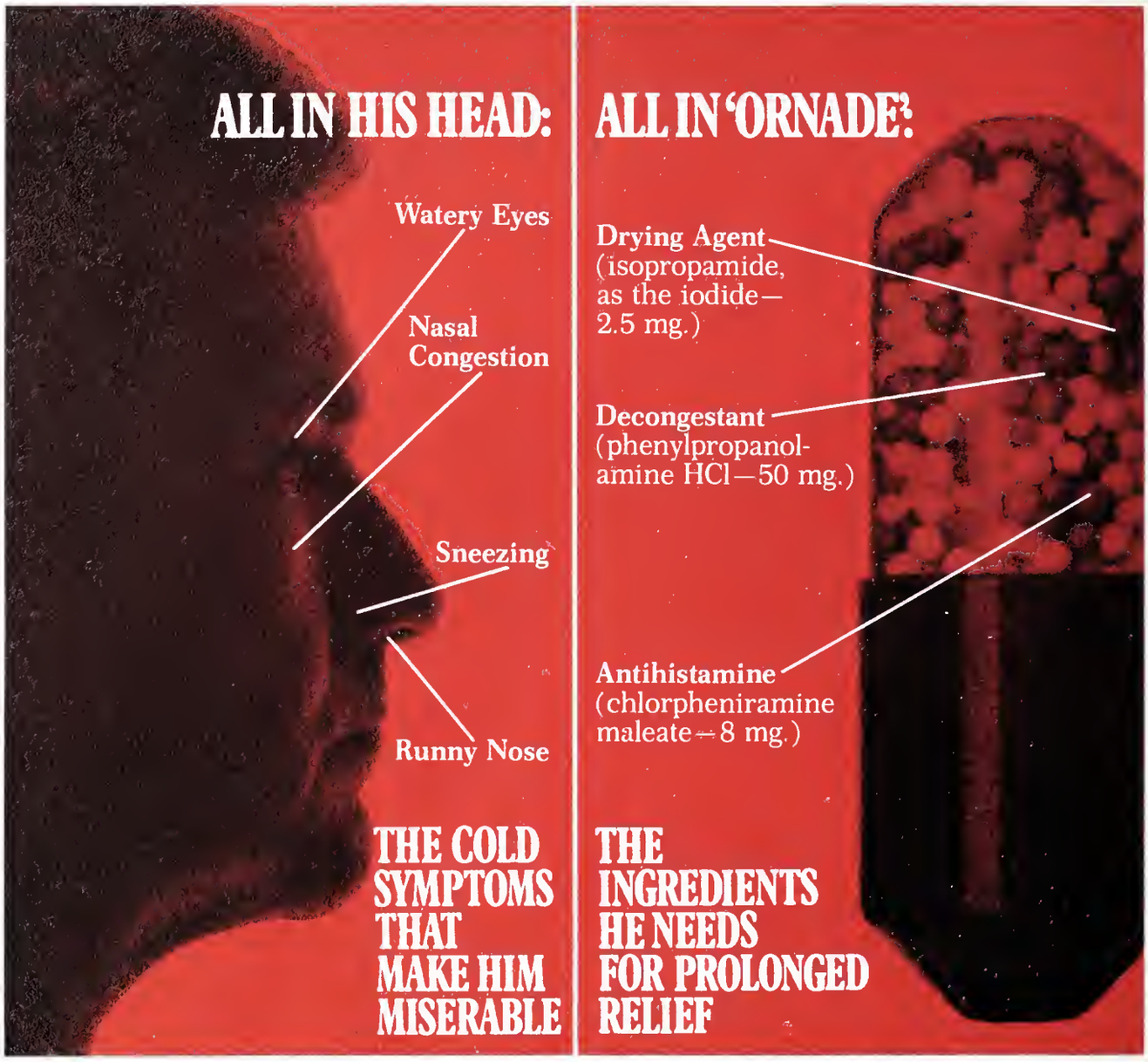

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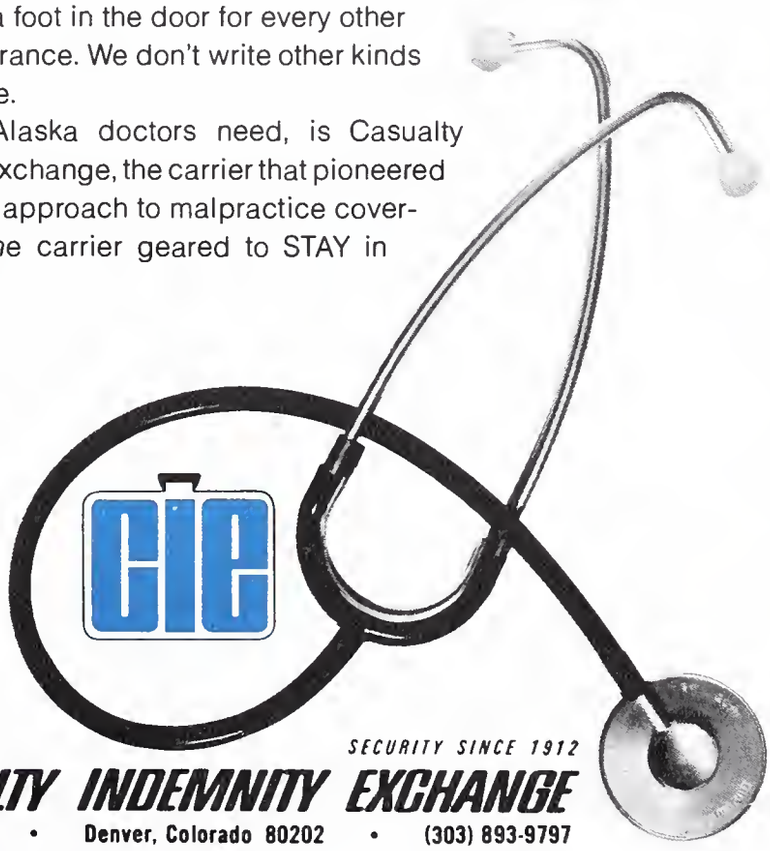

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ALASKA MEDICINE

Official Journal of the Alaska State Medical Association

Official Journal of the Alaska Dental Society

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APPLICATION TO MAIL AT SECOND CLASS POSTAGE RATES IS PENDING AT ANCHORAGE, ALASKA

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October Cover — "Kachemak Bay" by Paul Eneboe M.D.

DAVID R. L. DUNCAN, M.D.

1909 - 1972

Born 2/12/09 in Denver, Colorado. Deceased 8/13/72 in Anchorage, Alaska.

He received his BS degree in 1929 at the University of Denver, a Ph.D. in 1941 at the University of Chicago, and MD in 1946 at the University of Colorado.

Dr. Duncan held a Fellowship in Chemistry and Biology at Western Reserve University, Cleveland, Ohio, from 1937 to 1940. He served in the U.S. Army from 1943 to 1945. He was Health Officer in Colorado, first at Trinidad and later Aurora, Colorado, from 1949-1954. He was with the Indian Health Service in the lower states from 1954-1958.

Dr. Duncan came to Alaska in 1958 as Chief of Maternal-Child Health and Crippled Children's Services in the State Department of Health and Welfare at Juneau and served there until 1962. From 1962 to 1969 Dr. Duncan was in Anchorage, first as Medical Director of the City of Anchorage Health Department and later as Director of the Greater Anchorage Area Borough Health Department. The Department was greatly expanded during his tenure. He was held in high esteem by his staff. He contributed to many health-related and other community activities during this period.

Dr. Duncan was Service Unit Director at the PHS Alaska Native Hospital in Tanana from May 1970 until the time of his death.

Mrs. Irma Duncan, Dr. Duncan's widow, is a biochemist with the Arctic Health Research Center at College, Alaska. His son, Paul, formerly on the staff of the Alaska Native Medical Center, is now a resident in Internal Medicine at Albuquerque, New Mexico. He also leaves another son, David, who is an Engineer with the Public Health Service in Las Vegas, Nevada.

Dr. Duncan's friendly presence will be greatly missed by his many professional associates throughout the State of Alaska.

MR. MILLER REMEMBERED

Pale green walls
green shutters,
light in the room
seems clear
and faint
sea green.

You, in cool white,
eyes bulging,
lie
in all the tubes,
lines we've thrown
to you,
a drowning old bull seal,
plethoric jowls
now brushed with purple

Dead seals
sink
very slowly
through
green deeps to
darkening blue;
along the way
wetly
whitely
decay
in rubbery chunks.

To beat time before
breath
bubbles
to
a
stop
you gasp faster by the hour
as showers of emboli,
confetti:
crimson, lethal,
silt your lungs.

Tense round starting eyes
dart everywhere:
the nameless might
creep up
on you
unawares.

How do you feel?
Shaky tumbling whispers
All right All right All right
beg us, unsaid,
to back a lie
to oblivion
(this time —
this once —
it might leave you be).

I hear it
in your
marshy lungs;
the tide creeps closer.
Your guts have
gone on strike:
too much to do, too deep in debt.
After all these years of quiet coping
now they lie there: doing nothing.
No trouble to nurses,
"good" to the last;
scared as hell.

Old bull seal,
good natured as no
bull seal ever was,
you swam through alcohol and not sea water.
Of all your pals,
fellow swimmers
in the fog
who made their way
among the reefs
in the rye bays,
only the friendly killer whale,
your favorite bartender,
finally brought you to shore.
Stopped by just once,
asked how you were,
shook his head —
went back downtown to pour a few
for the same
old sots,
who made a small cairn to you
with anecdotes
for a night or two.

— *Martin Palmer, M.D.*

PRESIDENT'S PAGE

Joseph K. Johnson, M.D.

Joseph Johnson, M.D.

As all ASMA members are now aware, Medicaid is being readied for action with a target date of September 1, 1972. This date has been set by Commissioner Frederick McGinnis, although there is a possibility that it may be advanced to September 15 if the necessary forms, etc. cannot be printed and distributed in time. The participation application/agreement forms and covering memo sent out in June by the Department of Health and Social Services to all providers evoked considerable criticism.

A physician's Technical Review Committee was appointed several weeks ago and has met with the staff of the Department of Health and Social Services and representatives of other providers. The results of this Medicaid technical review conference were discussed in detail at the ASMA Executive Committee meeting on August 4, 1972.

The main areas of criticism were detailed in the letter subsequently mailed to our membership. As a result of our recommendations, a new application/agreement form has been mailed to all members. Even this is somewhat tenative and it may be several months before the final edition of the state and federal regulations are printed and distributed to all providers who have agreed to participate in the Medicaid program. At any rate, on the promise of changes which would largely eliminate the undesirable (or unworkable) provisions in the provider contract, we have agreed to urge ASMA members to sign up.

It should come as no surprise to Commissioner McGinnis that Medicaid has been met with less than wild enthusiasm by Alaskan physicians. Each year except one (1968), the ASMA House of Delegates has passed a resolution urging the legislature to reject it. However, the Department of Health and Social Services and its consultants finally amassed sufficient data to secure its passage.

The basic arguments in favor of Title XIX for Alaska were presented to the ASMA delegates at the annual meeting this year and are summarized in the Commissioner's article in the last (July) issue of ALASKA MEDICINE. While not actively supporting this legislation in the past, the ASMA now feels obliged to pitch in and help make it work. There are, in fact excellent reasons why Alaskan physicians (providers) should give the Department of Health and Social Services every assistance.

The most important reason is that the Medicaid program may well be a prototype of some larger scale federal or state administered health plan yet to come. With de-escalation of the war, our presidential and congressional candidates are taking up the issue of federally funded health care systems in earnest.

Right now, in order to get the Medicaid program working and working smoothly, the Department of Health and Social Services needs all the cooperation they can get from us. We in turn must insist that we get a program that we can live with in years to come. The Commissioner has already demonstrated his willingness to consult with us and to use our advice. We must be willing also to listen and consult with him and help him with his side of the program problems. This is an area in which organized medicine can effectively negotiate in your behalf.

There are still a number of issues which concern us and over the Department of Health and Social Services has no control. The chief issues are these:

> Congress clearly intended in the original Title XIX amendment to the Social Security Act to guarantee the eligible recipient a free choice of physicians and to the physician full and prompt reimbursement of his customary fees. These objectives have been gradually watered down since 1965. In 1970, the U. S. Department of Health, Education and Welfare arbitarily (and possibly illegally) reduced physicians' compensation under Medicare to the 75th percentile of locally prevailing fees. This, we understand, will also apply to Medicaid payments. On top of this we now have the administration's wage-price curbs which are highly discriminatory against physicians. What can we do about these unpleasant facts? What can Commissioner McGinnis and the Alaska Department

of Health and Social Services do about them? Well, the AMA is supporting suits testing the legality of HEW's 75 percentile ceiling as well as the discriminatory price curbs. Our Department of Health and Social Services obviously can do nothing about decisions rendered by the U. S. Department of Health, Education, and Welfare. Under the law, providers who find they cannot live with the fees and reimbursement schedules and procedures under Medicaid and Medicare are free to withdraw on written notice. However, the massive withdrawal of participating providers would further desecrate the original congressional intent to provide free choice of physicians to the eligible; the fewer participating doctors, the less would be this choice. Would we want this? Would the Department of Health and Social Services want it? No one really knows at this time, but we must give Medicaid a fair trial. Remember the old motto, "If at first you don't succeed, to hell with it."

Turning to other matters, the Executive Committee considered the Education Committee's report on the Washington/Alaska Regional Medical Program's proposal for patient care appraisal in selected hospitals in Alaska. It was decided to wait another year to observe further the results of this program in Washington state before making a formal application for funding of a program in Alaska. I know this was discouraging to Bill Kinn, M.D., our Education Committee Chairman, who put in a lot of time and effort studying the program. I am afraid, however, that our thinking is still pretty much colored by RMP's past performance in Alaska.

We are pleased to learn that the First Alaska Health Congress, was in addition to several other firsts, a successful operation financially. We actually came out ahead.

In this era of third-party payments for health care, it has become increasingly important to us to have some sort of yardstick or guideline for determining usual and customary fees in the various geographic areas of this state. Although by no means mandatory or officially endorsed by the ASMA, the 1969 edition of the California Relative Value Studies is widely used in Alaska and is generally acceptable to third-party participants. I would like to call your attention to the questionnaire we sent out regarding its use in your area. If you have not already done so, please take a few moments to complete this form and send it back to the ASMA office. It is important to you now and will be more important to you in the future.

The ASMA Executive Committee will meet every month on the first Friday. The next Council meeting will be in January as usual. Most of the Executive Committee meetings will be held in Anchorage, though we plan to have two Executive Committee meetings in Fairbanks and probably one (during the legislative session next year) in Juneau. A schedule of Executive Committee meetings for 1972 is as follows: September 8, October 6, November 3 (in Fairbanks), December 1, January 6, 1973 (Council meeting).

If you have anything you would like to put on the agenda for one of these sessions, be sure it gets to the office in Anchorage at least ten days before the scheduled meeting.

COMMISSIONER'S PAGE

Frederick McGinnis
Commissioner
Department of Health & Social Services

It is again my pleasure to have been accorded the opportunity to provide comments to readers of *Alaska Medicine* on behalf of the Department of Health and Social Services.

Before going further, I wish to express my sincere thanks to all members of the Medicaid Technical Advisory Committees, particularly Dr. Rodman Wilson, Dr. Glen Crawford and Dr. P. William Hardie, of the ASMA; and Dr. Robert Brodie, Dr. George Fraley and Dr. Aubrey Stevens of the ASDA, for their dedicated participation in the Medicaid Conference in Anchorage, July 28-29. Many of the recommendations of the committees were incorporated in finalized versions of the provider manuals, invoices, and service preauthorization and invoice adjustment forms. As of this writing, all phases of the Medicaid program are going well.

OFFICE OF ALCOHOLISM PROGRAM PROGRESS

The thrust of the Department's Office of Alcoholism to establish programs under the continuum of care approach, has begun to show very heartening results. With the 3 1/2 million dollars available for funding these programs, a comprehensive model program has been organized in Fairbanks. Assessment of the effectiveness of each area of care provided to the alcoholic, as well as the potential for spotting possible areas of difficulty with regards to staffing, administration and operation, is expected to provide the Department with invaluable information as we expand such programs through the State.

Fairbanks now has five areas of service for persons afflicted with alcoholism. These are: (1) information, education and referral resources; (2) emergency care facilities; (3) rehabilitation programs which provide 24-hour-a-day structured programming; (4) transitional facilities which allow the individual to have part-time residence in a therapeutic environment and to reach out into the community for employment, recreation and social contact; and (5) out-patient counseling programs.

The decision has been made to staff these programs, and those to follow, with resident Alaskan paraprofessionals. Experience in other areas of the country has shown that for the vast majority of individuals suffering from alcohol problems, the properly supervised paraprofessional can provide a most effective treatment resource.

Frederick McGinnis

All program personnel have been encouraged to work closely with local Alcoholics Anonymous groups, in view of the demonstrated value of this organization.

Additionally, the Office of Alcoholism is preparing a list of all treatment facilities in Alaska which will be made available to the Medical Society.

As all our programs and efforts crystallize, we anticipate making great strides in bringing Alaska's critical alcoholism rate, and related social problems into more manageable dimensions.

COMPENSATION FOR VICTIMS OF CRIME

The Department is establishing an administrative office for support of the Violent Crimes Compensation Board, provided for during this past legislative session. Governor Egan will be appointing members to the three-man board, one of whom will be a medical or osteopathic physician, licensed to practice in Alaska.

The purpose of the board will be to provide for compensation (not to exceed $10,000) of innocent persons injured, or dependents of persons killed as a result of certain crimes, or in attempts to apprehend suspected criminals.

Though a number of cases handled through this office is not expected to be great, medical and dental consultation related to the extent of injuries sustained by innocent persons, may from time to

time involve several members of the medical and dental professions.

Compensations may be paid as a result of the following crimes: mayhem; indecent acts with children; kidnapping; murder, manslaughter; rape, assault with intent to kill, rob, rape; or poison; assault with a dangerous weapon; threats to do bodily harm; or lewd, indecent or obscene acts.

It is believed that the information gathering and analysis activities of this board may provide data of sufficient value to make possible the prevention of certain violent crimes.

MENTAL OFFENDERS — A CIVIL PROCESS OF LAW

The urgent and complex problem of providing maximum security confinement and psychiatric treatment of "mental offenders" is receiving continued and vigorous study by the Department.

Mental offenders are those persons who have been tried for crimes but are judged not guilty by reason of insanity, or those who have been charged with the commission of a crime but are not required to stand trial due to mental incompetence.

Alaska, having never had appropriate facilities for treatment of mental offenders, is faced with the following options:

1. Establish a contractual agreement with another state to provide treatment and security.

2. Create a special section at an existing correctional facility in Alaska under the auspices of the Division of Mental Health exclusively for the treatment and security of persons in the mental offender category.

3. Build a new facility, the sole purpose of which would be to provide treatment and physical security for all persons judged in need of such treatment.

4. Terminate or reduce one of the existing programs at the Alaska Psychiatric Institute and establish a maximum security section for treatment of mental offenders.

Inquiries have been, and will continue to be, sent out to other states in an attempt to provide for an interim solution to this problem, while remaining alternatives are being fully explored. However, it has been noted that other facilities in the United States are generally working at or above their capacity now, and states hesitate to shoulder additional responsibilities of this nature. An agreement with the State of Indiana was discontinued by Indiana officials two years ago, and subsequent inquiries have met with negative reaction.

The U. S. Department of Justice has been requested to provide technical assistance regarding the disposition of Alaska's mental offenders; however, because this matter involves a civil, rather than criminal process, Federal penal institutions as well as those in Alaska may not be involved.

MUKTUK MORSELS

Bob Ogden

MEDICAID

Medicaid has come to Alaska and few physicians are impressed with the program as originally proposed by the Department of Health and Social Services. Many of the problems of the program are a result of the lack of time given to the Department by the Legislature to implement the program. Medicaid became law in Alaska on June 27, 1972. Between June 27 and September 1, 1972 the Department was faced with implementing a very complicated and extensive medical assistance program.

The program (Medicaid and General Relief Medical) will take the place of the old welfare medical program and will provide the following service to *eligible recipients:*

1. in-patient hospital
2. out-patient hospital
3. physician services
4. home health care
5. skilled nursing home care
6. screening and diagnostic service
7. transportation
8. limited dental care
9. prescribed drugs

Now that the program has begun, the Department is revising procedures that are obvious problems for providers of medical services and the Department. The Alaska State Medical Association's Technical Review Committee on Medicaid has met twice with representatives of the Department to work out physician problems with the program. The first meeting was held on July 28, 1972, when numerous suggestions were made by the committee to help make the program work. The most prominent problem at that time being the original provider contract proposed by the Department. Through discussion, with the cooperation of Commissioner Fred McGinnis, the ASMA's Technical Review Committee was successful in having the original contract disposed of and a new, much less binding contract transmitted to potential providers.

Recently (September 19, 1972) the Technical Review Committee again met with the Commissioner and his staff to negotiate detailed changes in the billing and patient authorization procedures currently required by the Department. The following position paper was given to the Commissioner to begin negotiations.

MEDICAID POSITION AND DISCUSSION

Since receiving the Medicaid manual for practitioners, out-patient hospital facilities, and home health care agencies, we have found a number of requirements in the Medicaid manual that are unworkable in the physician's office. We also have questions regarding some parts of the program that are not clear in the manual. Our questions and some discussion are as follows:

I. WHY IS IT NECESSARY TO HAVE A SPECIAL BILLING SYSTEM FOR REIMBURSEMENT OF SERVICES COVERED BY MEDICAID?

At the present time in Alaska there are numerous third-party financial resources available to patients:

1. Private Insurance Companies, Aetna, Blue Cross, etc.
2. USPHS Indian Health Service
3. Medicare
4. Veterans Administration
5. Office of Vocational Rehabilitation
6. Etc.

In all cases of the above third-party resources, physicians use the same procedure in their office for billing:

1. The 1969 California Relative Value Schedule is used as a guide in procedure description and coding.

2. Majority of physicians do not use (and it is not requested from any other third party) the ICDA codes for diagnosis. However, those who do use the ICDA codes do so only through a computer system.

3. As you will note in reviewing the attached samples of third-party billing forms, they are fairly similar in information requested. Many of the physicians in Alaska use the standard form approved by the Health Insurance Council of America. *The form proposed for Medicaid's use is very difficult when compared with others, and is thus time consuming and alien to the physician's office staff.*

ASMA POSITION:

A more standardized system *must* be developed for the Medicaid program. Until an agreeable system can be worked out between physicians and the Department, we ask the Department to honor the normal billing form submitted by physicians as long as the physician's form contains all information needed by the Department to meet federal regulations in administrating the Medicaid program; i.e., authorization numbers, 1969 RVS procedure codes, patient identification, etc.

II. WHY IS THERE CONFUSION BETWEEN THE INDIAN HEALTH SERVICE AND THE DEPARTMENT OF HEALTH AND SOCIAL SERVICES AS TO WHO IS ELIGIBLE AND WHAT SERVICES WILL BE PROVIDED TO NATIVE ALASKANS ELIGIBLE UNDER MEDICAID?

It has been reported to us by our members (predominately in the Kenai Peninsula area) that when their offices call a Department field office for authorization to provide care to a native person under Medicaid they are told to take care of the person under their Indian Health Service contract, or they are told Medicaid will pay for only a portion of the care. The same type of response is received when contacting the Indian Health Service about care for the native under contract care.

ASMA POSITION:

A clear-cut statement should be sent from the Department to all providers and Department local offices stating the Department's interpretation of the native person's rights under Medicaid. This statement should be jointly issued with the Indian Health Service.

III. WHAT TYPE OF ADJUDICATION PROCESS IS PLANNED UNDER THE PROGRAM?

From review of the manual we cannot find any indication of how disputed bills are to be adjudicated. This is very important to the future development of the program and participation of physicians in Alaska. If a fair and equitable adjudication process is not set up a large number of physicians will discontinue participation in the program.

ASMA POSITION:

The ASMA would like to propose an adjudication process to the Department; and, through a partnership between the providers and the Department, adopt and implement an adjudication process that meets all requirements and which is agreeable to all parties.

It is imperative that a permanent Medical Advisory Committee to the Medicaid program, as called for in the federal legislation, be appointed. And it is important that this Medical Advisory Committee be *intimately* involved in the future development of the Medicaid program for Alaska.

It was the feeling of this writer that the problems described in our position paper, our suggested solutions to these problems and others discussed were well received by the Commissioner and his staff, and will be implemented in the near future.

If you are having any problems with the Medicaid program, please inform the ASMA office at 277-6891 so that we can formally inform the Department of all difficulties.

FUTURE MEDICAL SYSTEMS COMMITTEE ACTIVITIES

The ASMA's Future Medical Systems Committee has submitted the following statement to the Arctic Health Research Center at the University of Alaska for inclusion in a reference manual they are preparing for a conference on the "Effect of the Alaska Native Land Claims on the Alaska Native Health". The conference will be held in Fairbanks on October 28-31 to discuss the ramifications of Section 2 (c) of the Native Land Claims Act which, in part, states "*the secretary is authorized and directed, together with other appropriate agencies of the United States government, to make a study of all federal programs primarily designed to benefit Native people and to report back to the Congress with his recommendations for the future management and operation of these programs within three years of the date of enactment of this act.*"

A PLAN FOR A HEALTH CARE SYSTEM FOR ALL ALASKANS

The Alaska State Medical Association proposes a health care system for Alaska for the next 15-20 or more years and discusses the transition period. We emphasize quality and methodology of delivery of care first and comment on administration and funding second. Premises are:

I. The goal is to provide good health care to all Alaskans by using resources such as manpower, facilities, money sources, and communication systems effectively.

II. Variations in quality of care will continue to exist, but efforts should be made to minimize them. Differences should be explainable either by geographic location or fluctuating levels of competence of individual health professions rather than because of race or economic status of the patient.

III. Sanitation and engineering aspects affecting general health are increasingly being transferred from federal, state, and local health departments to environmental protection agencies. This is probably good, but liaison with those who are most familiar with disease must be preserved. Traditional governmental health activities, such as control of communicable diseases, health education, and collection of statistics will be integral parts of the system and will require new and greater coordination between governmental and non-governmental agencies and programs than has heretofore existed.

IV. It seems probable that the state government will be more involved in the health care system as a funding source, as the federal government turns more and more to revenue sharing and research. De-centralization of control and administration of health care will occur, at least for a time. The State, Indian Health Service, Veterans Administration, etc., will become more responsive to regional needs. Control and administration of health care for particular areas of the state will largely rest with local organizations.

V. No one will seriously suggest that present resources (Appendix 1) be scrapped. The pertinent questions, then, have principally to do with better distribution, coordination, and management of present and added resources.

We feel that the best portal of entry for Bush areas into the health care system is through Bush schools. A school is an information and communication center in a small community and will become even more so with newer television modalities. It is the logical place for health care as well as for education, particularly since much of treatment and health preservation is fundamentally a matter of instruction.

A village having from 1-3 classrooms should have a teacher and a health aide who work closely together in general education, health education, and disease prevention, in a facility designed to have an aide station as well as classrooms. The health aide, assisted by advice from a communication modality, will specifically treat minor illnesses and injuries and will attempt to stabilize more serious disorders in preparation for transfer to a larger community.

In a village with 4-8 classrooms, we envision a small clinic in the school building manned by a health aide trained to the highest level of the Indian Health Service Aide Training Program, a registered nurse, or a physician's assistant who will work closely with a health educator.

In towns with a high school we anticipate that there will be a small, limited-service hospital with one or more physicians, health educators, sanitarians, and mental health workers.

In towns with a high school we anticipate that there will be a small, limited-service hospital with one or more physicians, health educators, sanitarians, and mental health workers.

In most cities there will be district hospitals with 4-10 physicians, including a surgeon, an internist, a pediatrician, and an obstetrician, and equipped to handle almost all illnesses and injuries. Cities will also have nursing homes.

In the two largest cities, presently Anchorage and Fairbanks, full-service medical centers equipped as well as any in the nation will exist. They will be staffed by 50-100

or more physicians supported by many other cadres of health professionals.

Appendix 2 lists these levels of health care.

We do not expect that a physician will reside permanently in communities smaller than those requiring a hospital. There will be hospital districts similar to our present system, though with better utilization. The present PHS districts will need to be realigned as local needs and control predominate and there will also be different utilization of some of the present small private hospitals. All district hospital services will be available to all persons living in the district.

It is planned that consultants from major medical centers will make regular trips to district and limited-service hospitals and possibly to villages. These visits will perform several functions.

1. Consultation to district physicians.
2. Direct services such as special surgery or diagnosis.
3. Training and supervision of health professionals and para-professinals in the district.
4. Health education to a community as planned by local health professionals or requested by citizens.
5. Appraisal of health services (quality control).

A sophisticated, statewide, individual health record system, and an automated communication system to receive to deliver almost instantaneously information to authorized persons, will be an integral part of the health care system developed. Initially, computer terminals will probably extend as far as limited-service hospitals with telephone or radio communications on to villages. Within 5-10 years, however, video communications will likely be available to every village so that observation of a patient, inspection of x-rays, transmittal of heart sounds, and the like can be made from afar. A physician, nurse, or physician's assistant can then tell a local health person what to do almost as expertly as if he were in the village.

Paralleling the health care system we plan an education system (now known as the Area Health Education System or the Community Health Education Network) to coordinate and provide educational opportunities for the high school level, village aide training, other paramedical training through nursing on to medical school and specialty training. At all professional levels it is planned to have continuing education. It is planned to utilize whatever expertise can be generated from sociologists, anthropologists, and the various Native cultures so that health care in all areas can be effectively translated to consumers.

At present the Alaska State Medical Association is not prepared to state what administrative form or forms a health care system should assume or who should own it. We do recommend that the concept of local participation and control be developed. Although the system is single as far as race and economic status are concerned, there may well be pluralistic administrative activities with central coordination. The concept of health maintenance organizations and medical foundations must be carefully explored. In addition, the future economic development of urban and Bush Alaska must be considered as there is no guarantee that governmental funding and control of health care will become or remain the ideal.

A transitional phase over the next 5-10 years is critical in the orderly development of the plan. It is our estimate that the structure of present federal programs must change even though federal funding, particularly for Native health, should remain at or above present levels. Physician and dentist staffing by the Indian Health Service may become difficult if the doctor-dentist draft ends in 1973. Because of this the open-staff concept of district Indian Health Service hospitals assumes more importance, because only in this way will private doctors and dentists be attracted to smaller communities. Local control of Indian Health Service facilities will probably hasten the organization of open-staff hospitals. It is our plan and hope that specialist consultants to district and limited-service hospitals will rapidly develop in the transition phase.

In summary, the Alaska State Medical Association suggests a wedding between health and education; a reorganized use of the resources of personnel, facilities, and money which we have at present; and development of new ways to transmit and use medical information to the end that everyone in Alaska has timely and equal access to good medical care.

Appendix 1

RESOURCES FOR ALL-ALASKA HEALTH CARE DELIVERY SYSTEM

MANPOWER

Physicians in state
Nurses
Physicians' assistants
LPN
Orderlies
Technicians
  Lab
  X-ray
  Other
Physical therapists
Dieticians
Opticians
Audiologists
Speech, reading therapists
Psychologists
Social Workers
Sanitarians
Etc.

FACILITIES

Hospitals, medical centers
Hospitals, medium district
Hospitals, small (limited service)
Alaska Psychiatric Institute
  Harborview Memorial Hospital (Valdez)
  Wesleyan Hospital (Seward)
Field health stations
Field aide stations
Nursing homes
Pioneer homes
Surgicenters
Alaska State Laboratories
Arctic Health Research Center
Private Medical Laboratories
Alaska Health Sciences Info. Center
Alaska Crippled Children's Treatment Center
Community Mental Health Clinics
Voluntary Health Agencies
Etc.

MONEY

Indian Health Service budget
Health insurance, job related
Health insurance, private
Accident insurance, auto, etc
Workmen's compensation
Fisherman's Fund
Medicare
Medicaid
General Relief Medical
Veterans Administration
Vocational Rehabilitation
Native Regional Corporations
Personal resources
State and borough public health programs
Etc.
Future: National Health Insurance?

Appendix 2

ALL-ALASKA HEALTH CARE DELIVERY SYSTEMS

Levels of facilities and Staffing

Level 1: Village, 1 to 3 classrooms, field aid station (out-patient and non-itinerant); aide, teacher-health educator.

Level 2: Village, 4 to 8 classrooms, field health station (holding beds for stabilization); aide or aides, nurses or physician assistant, health educator.

Level 3: Town, high school, small hospital (limited service hospital): 1 or more physicians, nurses, health educators, sanitarian, mental health worker.

Level 4: City, district hospital, nursing home, mental health clinic (departmentalized hospital); 4-10 physicians, including surgeon, pediatrician, obstetrician, internist; supporting health professionals.

Level 5: City, full-service medical center (major medical center); 50-100+ physicians, staffed and equipped as well as any urban center in the country; supporting health professionals.

BUSH MEDICINE — PUBLIC HEALTH COMMITTEE ACTIVITIES

Paul Eneboe, M.D., Chairman of ASMA's Bush Medicine-Public Health Committee, has prepared the following chapter regarding "Participation of Private Physicians in the Delivery of Health Care to Alaska Natives, 1972". This chapter will also be included in the reference manual given to all participants at the conference on the "Effect of the Alaska Native Land Claims on the Alaska Native Health".

PARTICIPATION OF PRIVATE PHYSICIANS IN THE DELIVERY OF HEALTH CARE TO ALASKA NATIVES, 1972

Private physicians provide care to Alaska Natives within the framework of the Alaska Native Health Service only when alternate resources in the direct care system of the Alaska Native Health Service do not exist or when the use of such resources is not feasible. The services provided by contract physicians are viewed as supplemental and secondary by Alaska Native Health Service officers responsible for the development of programs and budgets.

Private physicians who provide care to Alaska Natives fall into two rough categories: those physicians, generally specialists, who provide consultation services and backup to Alaska Native Health Service staff physicians or personnel, and general practitioners in smaller communities who provide direct care to Alaska Natives.

I. Consultation and Specialty Care.

In communities such as Anchorage or Sitka where a large Native Health Service facility exists, private physicians provide backup to the staff of the Alaska Native Health Service system. This is particularly true in the specialty and sub-specialty groups. Services provided include periodic ward visits and rounds, attendance at conferences and teaching sessions, performance of surgical procedures, field trips, involvement in teaching programs and, rarely, administrative assistance. The utilization of private physicians varies greatly from one department to another and is dependent upon the needs of the department, the availability of personnel and resources within the direct care system, and on the personalities involved.

The relationship between staff physicians and private physicians varies greatly from one department to another and from one town to another. For the most part, the relationships are cordial; but from time to time, within some departments personality conflicts have arisen which have been detrimental not only to the physicians involved, but to patients. Such personality conflicts have resulted in (1) less-skilled personnel performing procedures rather than utilizing more highly-trained private physicians who are available (2) the unnecessary transportation of patients to outside medical centers when physicians skilled in certain special procedures exist and practice within the state of Alaska.

Conversely, there exists within some departments exceptionally cordial and productive relationships between staff and private physicians. These relationships have resulted in exceptional programs of much benefit.

The last few years have seen the migration of a large number of exceptionally skilled, highly-trained private physicians to Alaska, particularly to the Anchorage-Fairbanks area. Many of these physicians practice specialties or sub-specialties heretofore unavailable in Alaska. Because of administrative practices of the Alaska Native Health Service, the skills of these physicians are not uniformly available to Alaska Natives.

II. Direct Care by Contract Physicians.

In larger communities such as Fairbanks, Juneau, and Ketchikan private physicians provide care to Alaska Natives who are first seen by Alaska Native Health Service medical officers. These Alaska Native Health Service physicians provide for primary care; have hospital privileges in their respective communities; and, when the need warrants, refer patients to appropriate contract physicians or to larger Native Health Service facilities.

Relationships between private physicians and clinical officers are usually cordial and pleasant. From time to time personality conflicts and medical differences have arisen. The most persistent controversy, which sometimes becomes loud and bitter, is the charge that medical officers underutilize community facilities by needlessly transferring patients out of their home areas to larger Native Health Service Centers.

Specialists practicing in these communities sometimes find it difficult to maintain an adequate volume of patients with medical problems in their specialty fields. This, coupled with the chronic problem of low occupancy of community hospitals, makes the transportation or

funneling-off patients who could be treated in their home area detrimental to the entire comminuty. This practice makes it difficult for smaller communities to attract and maintain skilled specialists, and for the hospital to keep an occupancy rate which would maintain solvency and the skill of their personnel.

In the communities of Kodiak, Seward, Homer, Soldotna, Kenai, Palmer, Glennallen, Valdez, Cordova, Tok, Haines, Petersburg, Wrangell, and occasionally Seldovia there are private physicians who provide care to Alaska Natives residing in the respective communities. Alaska Natives make up a few percent to almost half of the population, depending upon the community. The type and amount of care provided by private physicians varies greatly and is dependent on the size of the community, its geographic location, facilities and services available, and economic situations.

Private physicians provide the bulk of the primary care, including obstetrical and in some cases emergency surgical services, to Native patients in their respective communities. In order to receive this care the patients must come to the physician's office or to the community hospital. As yet no mechanism exists which permits private physicians to provide routine field trips and preventive health services to the Natives living either in local communities or in areas surrounding the community. The Alaska Native Health Service medical officers from the appropriate service unit hospital, such as Mt. Edgecumbe or Anchorage, make annual or biennial trips to villages surrounding the respective communities. These staff medical officers provide preventive medical care; perform periodic examinations; provide, on occasions, refractive and dental services; refer patients with more complicated problems either to the private physician or more usually to the nearest Native Health Service facility; and treat whatever illnesses are present at the time of their visit. The field health program of the Alaska Native Health Service system is excellent, and the field trips into most of the communities and villages are needed and appropriate. However, there are some areas where private physicians are willing and able to provide the field health trips, including preventive health and educational programs. Because there is no mechanism to permit private physicians to participate in their respective areas, Indian Health Service staff physicians continue to provide the outlying care and field trips. This creates an unnecessary fragmentation of services and at times has led to confusion, duplication or inconvenience to Alaska Native patients.

The Alaska Native Health Service has developed a system for providing modern medical and health care to Alaska Native patients scattered over vast areas, of which it is justly proud. The Center is the Alaska Native Medical Center in Anchorage, which has a wide representation of multiple specialties. This is seconded by a number of Bush hospitals such as Bethel, Kanaknak, and Tanana; supplemented again by field health stations; and, at the local level by the village health aide. This is a system in whcih Natives in the farthest village can be seen initially by an aide; referred to either a field station or a Bush hospital; and, if the problem is complex enough, transferred or referred to the medical center in Anchorage. Conversely, when the problem is resolved there is a smooth flow of information and communication back through the Bush hospital and to the health aide so that the patients receive appropriate follow-up in care. *This system breaks down when it is applied to communities in which private physicians provide the primary care.* While the private physician practicing in a remote community of Alaska is exactly a duplicate of his counterpart in a Bush hospital such as Bethel, he is treated in a vastly different fashion both objectively and subjectively. The physician in the Bethel hospital or Kotzebue hospital is a member of the team while the physician in private practice is an outsider. There is no mechanism other than the willingness or initiative of the individual private physician which permits the consistent, smooth flow of patient information back and forth. It is possible for a private physician to provide care to Alaska Natives for literally years without keeping any resemblance of adequate medical records. There is no mechanism whereby the records or discharge summary of an Alaska Native patient, referred by a private physician for a complicated medical work-up, are returned to the private physician in a routine and prompt manner. Generally to obtain such discharge summaries or patient information, the private physician has to wait two or three months and write letters, sometimes several for summary. This complete absence of a system for patient information exchange is detrimental to the care of Alaska Native patients.

Surrounding several remote communities in which private physicians practice, are villages in which there are "practicing" village health aides. These aides provide great amounts of primary care to their respective villages and are in several cases highly trained and skilled people. Several of these aides refer and consult routinely with private physicians in their respective areas. Ethically and legally this makes the private physician responsible for the actions of these aides. Yet there has been no attempt on the part of the Alaska Native Health Service to include private physicians in the training or evaluation of these aides. In fact, trainers and personnel responsible for the evaluation and continued education of the health aides have traveled through communities in which private physicians are practicing on their way to see village health aides without ever bothering to stop and consult with the private physician on problems that he may be having with the aide or to obtain an evaluation of the aide. By ignoring and excluding the private physician, the Alaska Native Health Service is not only losing a valuable resource in training and guidance, but further promoting the fragmentation of medical care and discouraging confidence and communication which are so vital to any type of health care system.

Those private physicians providing contract care to Alaska Natives are uniformly dissatisfied with the administration of the contracts. The complaints range all the way from charges of gross incompetence of Alaska Native Health Service administrative personnel to dissatisfaction with the philosophy of the contract which permits care to the patient regardless of economic status and ability tc pay. Private physicians uniformly cite the lack of adequate mechanism for effective input. Letters from physicians with complaints frequently go unanswered, or they receive quotations from manuals and administrative orders which do little to resolve the problems at hand. If they present problems in person they are shunted between one administrator and another until they give up in confusion and disgust.

In many of the communities in which private physicians practice there are no Native Boards of Health, and Native organizations are just now forming. As yet there has been no way other than hearsay for Alaska Native patients to express satisfaction or dissatisfaction with the quality of care they are receiving. As yet there has been no concerted effort in some communities to encourage Alaska Native representation on respective community Boards of Health or Hospital Boards.

In summary, from the viewpoint of Alaska Native Health Service administrative personnel, private medical care is a secondary or supplementary resource. Contract physicians fall into two major categories: consulting specialists assisting staff physicians and personnel, and contract private physicians providing direct care to Alaska Natives, generally in rural communities. Personality conflicts and administrative policies occasionally deny Alaska Native patients access to high-level specialty care

available in the State of Alaska. In rural communities with resident private physicians, these private physicians provide the bulk of primary care to Alaska Native patients. This care is unnecessarily fragmented by Alaska Native Health Service policies and attitudes. Private physicians are dissatisfied with the contract administration and are prevented from providing more effective coordinated service by Alaska Native Health Service policies. In many communities there is still no mechanism for Alaska Natives to express their needs and desires for health care and services.

INTERNAL REVENUE SERVICE REQUIRES A SIGN REGARDING FEES

Physicians are reminded to have clearly posted in their offices a sign regarding a schedule of base fees. A sign like the one printed after this paragraph can be purchased from the JOURNAL OF THE AMERICAN MEDICAL ASSOCIATION, 535 North Dearborn Street, Chicago, Illinois 60610.

to all my patients

A schedule of base fees of my principal services and each change in such fees is available in this office upon request, as required by the Price Commission.

American Medical Association

SEWARD

E. A. WATSON, M.D. has closed his practice in Seward and moved out of State.

JOHN NOYES, M.D., the only physician in Seward, needs assistance badly; physicians interested in starting a practice in Seward or interested in part-time or locum tenens work are asked to contact Dr. Noyes at 224-5231.

NOME

Donald Denning, Administrator, Maynard McDougall Memorial Hospital, tells us that the hospital is in critical need of a medical director. Any physician interested in full or part-time practice in Nome is asked to contact Mr. Denning at 443-21.

JUNEAU

JUNEAU HAS A CRITICAL SHORTAGE OF PHYSICIANS, especially in Family Medicine, Pediatrics, and Obstetrics-Gynecology. GARY HEDGES, M.D., President, Juneau Medical Society, asks that anyone who knows of a physician who might be interested in practicing in Juneau to please contact him or the Bartlett Memorial Hospital administrator at 586-2611 or 586-6050.

ESTOL R. BELFLOWER, M.D. has begun the practice of Radiology in Juneau. Dr. Belflower was in the Air Force in Anchorage and practiced General Practice at the College Medical Center in 1970-71. Dr. Belflower took his Radiology residency at Georgia.

F. ROBERT HOLTER, M.D. recently appointed Director of the Division of Mental Health, Department of Health and Social Services, State of Alaska, has resigned his position. At this time it is not known what Dr. Holter's plans for the future are.

SOLDOTNA

DAVID S. GRAUMAN, M.D., a board eligible Internist, has joined the Central Peninsula Clinic in Soldotna. Dr. Grauman received his training in the San Francisco area, is married, and his wife's name is Melody.

PETER E. CANNAVA, M.D., a board eligible Ophthalmologist, has joined the Central Peninsula Clinic in Soldotna. Dr. Cannava practiced in Maryland before coming to Soldotna. His wife's name is Linda and they have five children.

ELMER GAEDE, M.D., will be serving a locum tenens in Glennallen for two months starting October 1, 1972. Dr. Gaede will work at the Glennallen hospital while JAMES PINNEO, M.D. takes a much needed and deserved break "outside"

FAIRBANKS

RICHARD RICKLEFFS, M.D., has recently become associated with the Fairbanks Medical & Surgical Clinic. Dr. Rickleffs practiced General Practice in Hoopa, California for 20 years before joining the Fairbanks Clinic.

CALVIN P. CORMACK, M.D. has recently begun the practice of General Practice with the Tanana Valley Clinic. Dr. Cormack comes to the Clinic from Oregon.

WAYNE W. MYERS, M.D., has recently started part-time Pediatrics at the Tanana Clinic. Dr. Myers is currently in the military and considering starting a full-time practice with the clinic.

THE FAIRBANKS MEDICAL & SURGICAL CLINIC has recently begun an 8,000 sq. ft. expansion project. New space will provide offices for an ENT section, urology section, orthopedic wing, and increased administrative space.

The WAMI program (University of Washington Regionalization Program) has started again at the University of Alaska. Twelve medical

students are at the University this year. As part of their experience in Alaska, the students spend one day a week in private physicians' offices in Fairbanks. Past experience has shown that students and the physicians acquire a great deal from this experience.

ANCHORAGE

MICHAEL B. ARMSTRONG, M.D. has begun the practice of Internal Medicine and Rheumotology at the Anchorage Medical & Surgical Clinic. Dr. Armstrong was most recently with the United States Public Service in Anchorage. He took his residency at the New England Deaconess Hospital in Boston, interned at Emanual Hospital in Portland, and attended medical school at the University of Washington in Seattle.

DOUGLAS G. SMITH, M.D., has begun the practice of Orthopedic Surgery at the Anchorage Medical & Surgical Clinic. Dr. Smith recently completed his orthopedic residency at Los Angeles Orthopedic Hospital; took his internship in Los Angeles County General Hospital, and attended medical school at Harvard.

KENNETH T. RICHARDSON, M.D. has begun the practice of Ophthalmology at 1016 W. 6th Avenue. Dr. Richardson was recently the Chairman of the Department of Ophthalmology at the University of Pittsburg. Dr. Richardson took his residency and internship in Pittsburg, and comes to Alaska with a great desire to get away from the smog and traffic of a large city.

JAMES PATTERSON, M.D. has entered the private practice of Ophthalmology at 825 L Street.

JOHN WRIGLEY, M.D. has begun the practice of Urology at 207 E. Northern Lights Blvd. Dr. Wrigley received his medical degree from the Temple Medical School, interned at Deaconess Hospital in Spokane, and took his residency in Urology at the Cleveland Clinic. Prior to taking his residency, Dr. Wrigley served with the United States Public Health Service in Anchorage and in Kotzebue.

THOMAS G. FELLER, M.D. has begun the practice of Neurology at 207 E. Northern Lights Blvd. in association with George Lyons, M.D. Dr. Feller attended medical school and received his neurology training at the University of Virginia Medical School. He spent his internship and a year of internal medicine at the Cleveland Metropolitan General Hospital.

KEITH BROWNSBERGER, M.D., PAUL S. CLARK, M.D. and A. R. SASLOW, M.D. co-authored a recent paper on trichinosis. Entitled "Bear Meat Trichinosis", the paper cites epidemiologic, serologic, and clinical observations from two Alaskan outbreaks. *Annals Internal Medicine 76:951, 1972.*

DAVID LEISTIKOW, M.D. is leaving Anchorage to begin General Practice in Colorado.

ALEX RUSSEL, M.D. has recently joined the Children's Clinic, 3300 Providence Drive, in the practice of Pediatrics.

A Chest Disease Seminar will be sponsored by the Alaska Academy of Family Physicians and the Alaska Tuberculosis and Respiratory Disease Association at Mt. Alyeska on December 2 and 3, 1972. Program and registration forms will be mailed very soon. For more information call Jerry Little, M.D. (272-4551) or Leo C. Kaye (272-2332).

The Alaska Congress of Parents and Teachers recently presented a certificate of appreciation to the Alaska State Medical Association in recognition of the ASMA's valuable services to the children and youth of Alaska. This certificate of appreciation was presented to the Association on the 75th Anniversary of the National PTA.

MARTIN PALMER, M.D. has left The Anchorage Medical Clinic and relocated his internal medicine practice at East Park Professional Center, 1815 South Bragaw Street.

We know that some Alaskan Physicians are writing articles regularly. Please drop the ASMA office a copy of recent or future publications, so that they may be noted in Muktuk. — Ed.

HORIZONS IN MEDICAL EVALUATION

Bob Johnson, M.D., *Kodiak*

The days of the isolated, self-sufficient, Jack-of-all-trades general practitioner are dwindling. With the mushrooming of the field of medicine, this mastermind can no longer be master. No mind is equal to this task and hence, we have developed the specialties, the super specialties and the computers to retrieve and utilize the available knowledge.

The role of the general practitioner has been discussed, debated, discarded, retrieved and finally revised into that of a family physician with an overview of the field, who is prepared to deal with common problems and to advise the family on the need for and method of obtaining specialty care. No longer isolated in this day of helicopter evacuation, he need not be everything to everyone, for specialized facilities are--or soon will be--available.

However, the family physician stands in great danger of falling behind. He is constantly faced with the need to re-evaluate his status. Under the name of peer review, medical audit and currently patient care appraisal, re-evaluation techniques are being instituted in hospitals throughout the country. Next comes their logical extension to clinic and individual practice.

We, in Kodiak, have been painfully aware of our deficiencies. Though members of the American Academy of General Practice and adhering to the educational requirements of this organization, we found ourselves "out of touch." This led to a request, in November of 1968, for a medical evaluation. The request was directed to the Washington/Alaska Regional Program and to the Alaska Native Medical Center. Each agency was asked "to send out a consultant who would have the chance to spend two to four weeks in our area observing the doctors at work, checking charts both in the hospital and in the clinic, following our procedures in the laboratory and x-ray departments as well as our nursing procedures and in general giving us a total evaluation and constructive criticism of the service we offer to this community." No immediate action was taken on this request simply because the means and methods of accomplishing such an evaluation were not available. But the idea did not die.

Finally, in December of 1970, a call was received from Dr. John Aase, local director of the Regional Medical Program in Anchorage, indicating that he had received word from Dr. Donal Sparkman, program director in Seattle, that they were ready to act and wanted a statement of our needs. Thus, we proposed an evaulation of the following areas in decreasing order of importance:

1. Doctors' individual level of proficiency.
2. Clinic's collective level of proficiency.
3. Patient management efficiency, hospital and clinic.
4. Physicians' assistants and their utilization.
5. Paramedical services, their accuracy and efficiency.

We received a letter from Dr. Ted Phillips, Director of the Division of Family Practice at the University of Washington, nine days later, enclosing the following outline of the project:

UNIVERSITY OF WASHINGTON
SCHOOL OF MEDICINE
Division of Family Medicine

PRACTICE EVALUATION PILOT PROJECT
Kodiak, Alaska
January 22-23, 1971

PURPOSES

1. Education--To assist the physicians in Kodiak in directing their continuing education efforts.
2. Development of an evaluation process for wider application.
3. Assist in development of Medical School Family Physician curriculum by descriptive analysis of a primary care clinic.

AREAS OF EVAULATION

1. Clinical Practice
2. Process of Patient Care--Clinic Operation
3. Community Needs--Met and Unmet

PROJECT STRUCTURE

1. Focus of evaluation--The Holmes Johnson Clinic, Kodiak, Alaska
2. Primary evaluators
   a. Francis C. Wood, Jr., M.D.--Associate Professor of Medicine, UW School of Medicine, Seattle.
   b. Amos P. Bratrude, M.D.--Affiliate in Medical Practice, UW School of Medicine, Seattle; Family Medical Center, Omak, Washington.
   c. Ted Phillips, M.D.--Acting Associate Professor and Director, Division of Family Medicine, UW School of Medicine, Seattle.
3. Secondary evaluators and resource people
   a. Marvin Turck, M.D.--Associate Professor of Medicine, UW School of Medicine, Seattle.
   b. Robert Day, M.D.--Professor and Chairman, Health Services, School of Public Health, UW, Seattle.
   c. Others--as yet undetermined
4. Project sponsor--Washington/Alaska Regional Medical program

PROJECT PROCESS

1. Clinical Practice
   a. Direct observation by primary evaluators of Kodiak physicians and clinic personnel in clinical practice.

b. Utilization of index diagnoses or problems for discussion and record review:
   1) Physicians of the clinic suggested five topics and two of these have been selected by the evaluators--Diabetes and Urinary Infection.
   2) Kodiak physicians to write down their own criteria of adequate care for patients with these two problems.
   3) RMP medical records librarian to abstract records of all patients hospitalized in past year and seen in clinic during a defined period with diabetes or urinary infection to see if above criteria met.
   4) Primary evaluators to review same records as a means of assessing care provided and the process of patient care.

a. Primary evaluators review records mentioned above and random sample of clinic records to assess:

   How are medical records used? Do they maximize efficiency and continuity of patient care?

   How is follow-up of patient problems effected?

   Is patient care "comprehensive" in terms of dealing with all four stages of medical care?

   i.e., Foundations of Disease
   Pre-symptomatic Disease
   Symptomatic Disease
   Rehabilitation and Chronic Disease

2. Process of Patient Care

   How do physicians and other clinic personnel share time and tasks?

   b. Primary evaluators observe operation of clinic for one or two days to assess same questions.

3. Community Needs-Met and Unmet

   a. Primary evaluators interview patients in clinic to assess:

      What problems do they bring to clinic?

      What medical or health problems do they have which they do not bring to physician?

      What do they see as the medical needs of the community?

   b. Primary evaluators interview key people in community to assess same questions.
   c. Primary evaluators interview people at random to assess same questions.
   d. RMP and/or state or local health department records reviewed concerning morbidity and mortality data for the community.

REPORT

The observations made and data collected will be compiled in a report to be used for at least the following:
1. Information of Kodiak physicians to help them plan practice approaches and continuing education efforts.
2. Development and refinement of such an evaluation process for wider application.
3. Development of curriculum for education of medical students and residents for primary care careers.

LOGISTICS

The following timetable is suggested:
1. Week of December 28: Locate and confirm personnel to act as primary and secondary evaluators--done 12/30/70.
2. Week of December 28: Confirm dates with Kodiak physicians--done 12/30/70.
3. Week of January 4: Kodiak physicians write down what they consider minimum criteria for adequate care of patients with diabetes and urinary infection--both hospitalized and ambulatory.
   e.g. What criteria used to judge adequacy of control of diabetes? (blood sugar level? Symptoms? weight? etc.)

   What frequency of visits to physician advised in controlled diabetes?

   When should cultures be used in evaluation and treatment of urinary infections?

   What length of treatment for usual uncomplicated urinary infection?

   What constitutes appropriate follow-up of patient with urinary infection?

   When are further studies indicated in patients with urinary infection?

   (Many other questions possible--these are only samples.)
4. Approximately January 11: (Prior to visit of Medical Records Librarian) Kodiak hospital and clinic staff identify all records as follows:
   a. Hospital records of all patients hospitalized in 1970 with diabetes and/or urinary infections.
   b. Clinic records of same patients.
   c. Clinic records of all patients seen in clinic with either of these two problems during a given recent time period. (One month is suggested and review of day-book may be necessary to identify patients. An alternative would be to note all such patients seen during the next two weeks--approximately January 4 to January 18.)
5. Approximately January 11-20: RMP Medical Records Librarian visit Kodiak and abstract hospital and clinic records identified above with respect to criteria established by Kodiak physicians.
6. Friday, January 22: Drs. Wood, Bratrude and Phillips arrive in Kodiak. Spend remainder of that day reviewing abstracts and records (possibly one man to observe clinic operation, one to interview patients, and one to review records).
7. Saturday, January 23: Dr. Wood, Bratrude and Phillips spend entire day in Kodiak observing clinic and practice operation during morning and completing record review later (or possibly continuing divided responsibility as above).
8. Sunday, January 24: Drs. Wood, Bratrude and Phillips leave Kodiak.
   (Note: it is possible one or more may be able to arrive earlier or stay later.)
9. By March 1, 1971: Report to be completed.

An article was prepared and published in the local newspaper, indicating that the Audit was forthcoming and urging members of the community to be quite frank in responding to questions that might be asked by the team. The names of the participating physicians were included.

In January of 1971, the Audit was completed according to schedule. In March the report was received and far exceeded the quality we would have thought possible in three days. We went to work attempting to institute some of the measures that were recommended. In April of this year, the

team returned for a repeat audit which was accomplished, this time in two days. A similar approach was used and the formal report is yet to be received, but the auditors were enthusiastic and felt that their efforts had resulted in substantial improvements in the Kodiak practice.

One of the major suggestions of the audit that we are in the process of implementing is that of what is now called "patient care appraisal." This involves drawing up a set of criteria for the management of patients with certain diseases in the hospital, as we did for diabetes and urinary tract infections for the first audit. We added alcoholism and its complications for the second audit and will continue with other diseases. A reference has been sent for in which criteria for the management of about forty diseases is contained. These are found in the *Hospital Utilization Review Manual*, edited by Beverly C. Payne, M.D., and published by the University of Michigan Medical School, Department of Postgraduate Medicine, Ann Arbor, Michigan, February 1968.

This article is submitted in an effort to stimulate others in the practice of medicine to consider similar techniques in evaluating their efforts. There is no reason such techniques should not be applicable to specialty clinics and to individual physicians as well as to a Family Practice Clinic such as ours. The benefits to be derived are only limited by the ability of the physicians involved to change.

MEDICAL AUDIT AND THE PROBLEM-ORIENTED RECORD

Robert Fortuine, M.D.*

The evaluation of medical care is becoming a lively issue for physicians today. It is not a new idea, of course, but the methods traditionally employed, namely tissue committees, CPC's, and medical record committees, have generated little enthusiasm on the part of either those auditing or those being audited. Nor is there much evidence in any case that the methods have been successful in doing much more than raising antagonisms between doctors. Only the most blatant examples of incompetency are generally brought to light and hospital staffs or county medical societies have then been more than reluctant to take the disciplinary action which is sometimes needed.

The great majority of doctors have always tried to do what they felt was best for their patients. They work long hours, often with critical shortages of staff, supplies, or hospital facilities. Understandably, they resent subjecting their work to the scrutiny of others, who may have no more than a superficial understanding of their patients' problems, the conditions under which the physician had to make his decisions, or even the technical aspects of his specialty. In a highly competitive medical community, moreover, personal animosities may also play a part. When put in a defensive posture under such circumstances, the physician under review is not likely to profit much from the experience.

Although the medical profession has always taken the leadership in reviewing the work of its members, it has received more than a gentle nudge in recent years from the clamors of the general public. Changes in the patterns of medical education and practice, insufficient health manpower, increased specialization, but most of all the almost exponential rise in medical care costs have caused the consumer to view the profession somewhat less romantically and tolerantly than heretofore. He is beginning to ask about the efficiency, relevancy, availability, quantity, and quality of the care he receives. The general public now finds Marcus Welby, M.D., no more credible a portrayal of real life than John Wayne with a blazing six-gun.

These concerns are reflected in the recent attempts to push legislation through Congress requiring peer review for Medicare and Medicaid patients. They are also reflected in the renewed interest shown by the AMA and by certain State Medical Associations, notably California, in the whole process of medical care evaluation. It is certain that any National Health Insurance legislation (which most observers feel is inevitable) will have strong safeguards not only to protect the health of the public but also to insure that the taxpayer's health dollar is spent wisely and efficiently.

The medical profession must itself promote the concept of medical care evaluation for several self-evident reasons:

(1) Physicians owe it to their patients to provide them with the best possible care and to protect them from incompetent practitioners.

(2) No one can fairly evaluate the care rendered by a physician except another physician with comparable training and experience.

(3) If the profession does not take the leadership in this area, the public will accomplish the same ends through legislative means.

How, then, can this responsibility be fulfilled effectively so that it has the support of both the profession and the public?

The problem-oriented record, as developed by Dr. Lawrence L. Weed[1,2] and explained by Dr. Allen Jervey in the April 1972 Issue of *Alaska Medicine*,[3] has encouraged a fresh approach to the audit of medical care. While traditional efforts have addressed themselves largely to the structure and outcome of medical care (Joint Commission on Accreditation of Hospitals, tissue review and death conferences, for example), the POR gives greater emphasis to the other major component of evaluation, namely the process of care.[4] Dr. Weed considers audit of records a fundamental tenet of his system. But he would have us go far beyond the time-worn emphasis on signatures, consents, surgical specimens, and the proper terminology of final diagnoses.

The essence of the problem-oriented record may be briefly described in terms of its four elements:

(1) A data base adequate to identify all problems.

(2) A titled and numbered problem list, which is complete and current.

(3) A plan for dealing with each significant problem.

(4) Titled and numbered progress notes relating to each active problem.

The medical record, kept in this manner, whether on a hospital ward or in a physician's

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office, is an effective tool for comprehensive continuing care, medical audit, self-education of the physician, research, and computer storage and retrieval. We shall limit ourselves here to medical audit and its inevitable by-product -- self-education of the physician.

Medical audit or peer review suggests the evaluation of a physician's work by a peer - that is, an individual with comparable or better medical qualifications or experience. The concept also implies, or should imply, the measurement of performance against a standard, either generally accepted principles of good care or, at the minimum, the reviewing doctor's own method of handling such a case. Using the traditional medical record, the problem immediately becomes one of incomplete data, undocumented decisions, forgotten circumstances, and lack of "feel" for the original situation. The standard record rarely reflects why the doctor made his decisions, or sometimes even what decisions were made.

A problem-oriented record is, if nothing else, organized. The patient's problems are set forth in an orderly fashion, with all data describing or assessing the progress of each problem easily retrievable by use of the numbered plans and progress notes. Repetitious notations, vague generalities, and free-standing particles of information are rigorously excluded from the record by the conscientious practitioner. Unfortunately, to be lucid is to be found out. If the record demonstrates not only the conclusions but the thought process of the physician, it also may become the damning evidence of clinical mismanagement.

But proving a doctor wrong is not the point of medical audit, for it helps neither the patient at this point, nor in most cases the doctor, for he is aggrieved and hostile under such circumstances.

An audit of medical care under the Weed system of records is basically a continuing education session. Both the auditor and the one audited should be present, together with other clinicians of the specialty or a related one. The process should be carried out with strict objectivity. The meetings should be short (as this method allows them to be) and include in a cyclical fashion every member of the staff. Each meeting should have a central theme, such as a certain type of disease or operation. Non-participation in this process should be grounds for appropriate sanctions set and enforced by the active membership of the hospital or medical group staff.

The essence of a problem-oriented audit may be summarized by a series of questions:[5,6]

(1) Is there a problem list and is it complete and current? This is the basic criterion for a problem-oriented record. One doctor cannot be damned for mishandling a problem when a second doctor has not even taken the trouble to find the problem or to determine how it might interact with other problems.

(2) Is the initial data base complete? The physician must have at hand not only the data necessary to define and support his problem list but also sufficient to uncover problems for which his patient might be reasonably at risk because of demographic, social or environmental factors.

(3) Are all data beyond the initial data base associated with a specific problem? Every examination, laboratory test, x-ray, or medication should be clearly tied in with a defined problem or else it must be adjudged superfluous and, therefore, expensive and possibly harmful to the patient.

(4) Are all the data on a specific problem easily retrieved in sequence and with complete currency? This is the essence of the organized and logical thought process that the problem-oriented record should demonstrate. A complex case with many interrelated variables becomes much easier to handle when the data are systematically sorted out.

(5) Has the physician shown good judgment in the selection of problems for detailed attention? It is axiomatic that a physician cannot do all things for all problems. It is his responsibility, however, to select logically and with a due sense of priority what needs to be done now, considering such factors as the acuteness, severity, or potential danger of the disease, the costs to the patient and the time and resources of himself as a physician. His plan for each problem should be written down, and should be carried out with reasonable dispatch.

(6) Has the physician used all resources available to him to deal with the patient's priority problems? Most physicians have been notably reluctant to play their traditional role as captain of the health team. Social workers, clinical unrses, public health nurses, dietitians, mental health workers, psychologists, physician assistants, and even other physician consultants are often grossly under utilized in the management of complex problems.

(7) Has the doctor handled his data scientifically and acted on accepted physiological principles? The emphasis here is less on what diagnosis was made, or what drug prescribed, or even what happened to the patient; rather, the question seeks to evaluate the doctor's thought process.

(8) Has the doctor made reasonable clinical decisions based on the information which is available to him? His standard of care for common problems should be at least that of the community in which he practices. If he deviates markedly from the norm, his peers (as well as his patients) have a right to ask why.

(9) Has the doctor made use of all sources of information available to him? Instead of asking why he didn't remember a rare syndrome or reference, we can more reasonably ask why he didn't call a consultant or why he didn't use the library, if indeed either were accessible. And, if they weren't, efforts should be directed more toward making such services available than toward criticism of the doctor.

(10) Finally, was the patient himself or his family adequately involved in the management of the present illness and the prevention of future illness? The record should reflect to what extent this important but often neglected responsibility was fulfilled by the doctor.

The evaluation of medical care as described in this paper can be threatening, but only to the doctor practicing sloppy medicine. The problem-oriented record, if used conscientiously, by its very nature improves the *process* of medical care and therefore presumably the outcomes of care. A doctor who organizes his thoughts and actions according to such a scheme has nothing to fear from medical audit. The emphasis remains as it should, on the art and science of medicine. The problem-oriented record simply requires evidence of the scientific method itself, often all too inapparent in the traditional practice of medicine.

Peer review, medical audit, medical care evaluation, - by whatever name - is here to stay and we should use the opportunity it provides to grow as physicians. When done sensibly and sensitively, it will improve the quality of care while increasing the unique satisfactions this profession offers to its practitioners.

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CONFESSIONS OF A FORMER HERETIC, OR SALVATION AS A PROBLEM LIST

Richard A. Bernstein, M.D.*

Weed and his disciples are to medicine what Nader's Raiders are to the consumer-directed industries. Both in zeal and mission, the efforts of the high priests of Problem Orientation are equal in intensity to the crusades of their advocate colleagues. And both groups are winning ground from a diminishing number of holdouts. As a former belligerent nonbeliever who was chastised early in his training for refusing to use the Problem Oriented Record, I know full well the arguments of the opposing camp.

My aim is not to proselytize for the Weed system. Rather, I would like to discuss what I feel are the two main arguments against it, and to suggest that they are based on misunderstanding and fear.

The first argument dismisses the Problem Oriented Record as a bookkeeping gimmick that consumes time and energy for what appears to be a rather meager return of information. House officers, especially interns, and attending staff at a hospital which has recently decided to "go Weed" are likely to use this argument, but for entirely different reasons. Interns bear the brunt of the 3:00 A.M. admissions. The chore of reviewing a fifty year old patient's chart, initiating a problem oriented work-up, and preparing a problem list before Attending Rounds the next morning, seem in those dim hours like adding insult to injury. But the chart had to be reviewed even under the old system, and it had to be done on admission regardless of the hour. The only difference is in the organization of data once they are located. The actual writing, even the first time through, takes little more effort than the narrative style. With practice, it can take less. For progress notes, or subsequent admissions, anyone who knows the system can quickly and easily bring the problem list up to date.

Various extensions of the bookkeeping argument are used by the staff physicians, many of whom are quite happy to "scribble a little note in the chart," but who are forced under Weed to think about both the form and the content of their words. Staff men tend to quibble about the mechanics of the system. Such questions as, "What if a patient has sixty problems; do I have to write them all down?" or "Which way does the arrow go for a recurrent problem that is temporarily resolved?" are common. These are logical, but of rather small print in importance. However, they can be answered logically by saying that there are few hard and fast rules in the grammar of the P.O.R. That which makes sense is right. The only real guideline is consistency, and the only pitfall is intensive care for the problem list and ward treatment for the patient. Those physicians who are willing to give the system a try generally work out their own personal approach. Those who won't accept it continue to find picayune reasons for so doing.

The second argument against the Problem Oriented Record is one that most doctors won't admit to using, even to themselves. The anxiety caused by the introduction of any new concept or plan is generally a reaction to its novelty. But some physicians feel threatened by the P.O.R. to a degree that is disproportionate to the amount of expected change. What is feared is that something or someone will come between the doctor and his patient. Whether it is the marginal notes of a service chief, or the cool eyes of a peer reviewer, there is great apprehension that the simplicity and openness of recording *a' la Weed* will somehow render the doctor vulnerable and prove him incompetent. Along with the fear of exposure is a certain amount of bravado about one's own method and one's own approach which "have served quite well since medical school, thank you."

Private practitioners, particularly surgeons, are most likely to feel these pressures. The man in private practice has usually developed a style he likes, a preferred routine, and timesaving shortcuts which he feels are helpful tools. He has chosen to work for himself rather than for a school or hospital. Why should he change his records if only he has to read them? The surgeon comes to a similar conclusion from a slightly different angle. His training has prepared him to make important decisions at the right time. He knows by heart the criteria that make cutting mandatory, and those that prohibit it. His analytic approach to every patient has been honed by years of experience. No amount of chart writing, regardless of what form, will change his method. If something goes wrong, he knows that he will be harder on himself than any surgical or pathological judgment committee would be. Why should he waste precious O.R. hours with further explaining or rationalizing? If the internist

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has time for that paper *angst*, the surgeon feels he hasn't.

While not all private practitioners are represented by these arguments, I have heard them often enough to allow the generalizations. The fear of being judged or misjudged by both associates and patients is one of the realities of our profession. But far from being the informer it is imagined by some to be, the Weed method with the quality control inherent within it, both encourages good medical practice and prevents misrepresentation.

The rules are simple. All that is required of anyone using the P.O.R. is that he make a sequential list of problems from the data he has gathered while taking a history, studying a chart, or examining a patient by any of the methods available to him. This list must be comprehensive. Each problem must be stated at the level of sophistication at which it is known. Renal colic and hematuria are not due to a kidney stone until the specimen is produced or its presence demonstrated. Mid-epigastric pain is just that until an upper G.I. series or surgery demonstrates an ulcer. This complete and literal handling of data on the problem list helps to insure two things. First, that we are not committing the grievous and all too common fault of omission. And second, that our mental gyrations and shortcuts, no matter how time proven, are not allowing us to reach unsubstantiated conclusions. The material we use to identify and support a problem is at our discretion. But hopefully our observations, methods, and diagnostic criteria will be sharpened by our being forced to think about each problem as a separate entity. Gone will be the dangerous prerogative of discarding a fact just because it doesn't quite fit. Even if it can't be explained, it must be reckoned with, once added to the problem list .

There is still room in the write-up to hear the hoof beats, and to list the zebras of a glorious differential diagnoses. But the facts as stated in the problem list ought to be as unbiased and free of conjecture as possible. The plans for each problem should follow naturally from the data available. The format of the Weed method alone serves both as teacher and critic. If we have been hedging, or rushing, or have been inconsistent, even while we were delivering what we considered to be good and conscientious care, the Problem Oriented Record itself, rather than any peer jury, will help to make us all better physicians.

IN DEFENSE OF FREE ENTERPRISE AND UNITED STATES DENTISTRY - THE WORLD'S BEST

R. A. Smithson, D.D.S.

For more than twenty-seven years, your editor has enjoyed the heritage of, and has hopefully contributed to, the finest dental group in the world, that of the United States of America.

We have observed magnificent and near miraculous changes in technique, procedure, concept, and patient relationship — all for the good of the patient and the practitioner alike. The best service at the lowest cost to the patient has always been the primary goal of dentists of the United States. As relevant research was published, there were always interested general practitioners who applied the findings clinically, again for the betterment of the patient. New teaching methods, constantly being revised by conscientious dental educators, were applied in dental schools, and along with the new techniques of treatment, resulted in finer and superior dental graduates.

In short, the dentists of the United States have enjoyed, 1) a better productivity, 2) better clinical results, 3) better opportunity for the furtherance of the patient and profession, and 4) better public image as a profession. We can now announce that dental disease is *totally preventable!* What a milestone! It is an incomparable situation, world-wide.

This treasure we have needs very careful guarding, for it is in great jeopardy. Not only are we faced with the loss of good dentistry for the present and future patient, but as taxpayers we will pay for this destruction of an acknowledged superior system and the establishment of the usual organizational — heavy governmental scheme which costs many times more for many times less.

Over this same time span of twenty some years, we have also observed to our chagrin and disgust, the evolvement of governmental and quasigovernmental systems promoted by do-gooders, politicians and thieves, which are aimed not towards the betterment of the patient at the lowest cost to him, but towards self-aggrandisement and political expediency. Countries other than the United States have followed this socialistic trend to a far greater extent than we, and with abysmal results at an unbelievably expensive cost. Today, the United States and Alaska are being subjected to these proven failures of effort under many guises and new names, for the same primary reasons. A total disregard for the patients health, and the general taxpayer and public monies are the ultimate and inevitable result. This is not a revolution to change leadership on delivery systems because of poor quality of the service or productivity of practitioners. On the contrary, it is because of the excellence of dentistry in the United States — the finest in the world — that we are now targets for the politicians and power seekers. Here is something good, something working well. Let's take it over and make the public think we can do it better, for less cost to them, seems to be the theme of the day. Lies repeated often enough somehow get accepted as truth by the public.

Sir Winston Churchill, after World War I, called the Versailles agreement a "sad and complicated idiocy". These words are particularly descriptive of the bureaucratic approach to our profession today, whether it be the federal, state, or local level. Incredibly, many dentists and their leaders agree to these socialistic concepts, if not completely, they agree sufficiently for the movement to gain momentum. We all tolerate these insults, encroachments, and highgrading maneuvers to some degree, but now there are those who actually define the dry-rotted incompetence of these systems and their administrators in one breath, and condone and further their purpose in the next. For example:

Dr. J. Richard Myles, then president of the Massachusetts Dental Society, said in a speech, "Administratively, by any test, Medicaid has been a nightmare. Through no fault of its own, Medicaid was conceived in confusion and nurtured in chaos. Is it any wonder there has been a crisis around every corner?" He went on to —

(1) blame the commonwealth for its inept and sloppy administration of the program.

(2) stated that the profession's prime interest was that of the patients dental health,

(3) decried the political football Medicaid had become,

(4) acknowledged the fact that a massive health program costs money and pleaded for "adequate" funds,

(5) demonstrated the fact that dental costs of the program decreased while other categories have increased,

(6) made the one sensible and coherent statement that "catch-up dentistry is always expensive" and that "costs for dental services under Medicaid have leveled off because thousands of patients are now on routine maintenance dentistry who for years neglected their dental needs."

Let us look elsewhere to see how others fare with a nationalized, socialistic health service.

A running, current appraisal of this variety of dentistry has been available for us all for many years. This is the section of International Dentistry, Great Britain, in the Journal of the American Dental Association. We all get this Journal, but how many of us read this section and interpolate it to our situation? It provided interesting reading in the past; now these columns are describing the events and situations we will face in the United States.

Excerpts follow from the last three issues, June, July and August of 1972, but I daresay any issue of the JADA in the last fifteen years will be revealing. Is this the future we face?

JADA June 1972 - DENTAL EMERGENCIES (Jan. 1972 BDJ) "There is still a large body of people who only seek dental treatment in an emergency — when they are forced to by inconvenience, discomfort, or acute pain — and a proportion of them will be driven to seek aid at night, on weekends, or on holidays. It is of no use to preach to the man or woman with acute pain on Saturday or Sunday that his or her condition is merely the result of neglect or ignorance. He or she wants treatment.

"In these days of a national health service, which many believe they pay for by a weekly stamp on a card, treatment is expected. If it is not obtained, justly or unjustly the status of the dental profession is diminished in a way that no assumption or adoption of titles will redeem.

" . . . The British Dental Association has for many years indicated its willingness to arrange a roster of dentists in the main population centers to deal with dental emergencies if accommodations and ancillary staff were provided. Since the state is now, to such an obvious extent, an interested party in the provision of dental care, it can be reasonably argued that it has a responsibility for the provision of the facilities required . . . "

International Dentistry — Great Britian, JADA July 1972, Dentistry in Group Practices. "Extention of the present role of dentistry in health centers to group practices is advocated in 'the organization of group practices'. (HMSO p.65) A report of the subcommittee states in its report: "During our visits to Health Centers we were impressed by the fact that dental suites — which were provided in many of these buildings — were rarely being used.

"We were told that they were used only by dentists employed by the local authority in the treatment of children and expectant and nursing mothers. This seemed to us to be a great waste of expensive equipment and accommodation."

JADA July 1972 Recruitment. "An editorial in the **Quarterly Dental Review** entitled "Public Ignorance and the Problems of Recruitment to Dentistry" contains the following excerpt:

"The perennial problem of recruitment to the dental profession was once again the subject of a full-day conference, organized by the General Dental Council, last Dec. 3. Three years elapsed since the last such conference and, with one or two notable exceptions in local areas, no evidence was offered which would lead one to believe that any national improvement had occurred in the interim. The dental schools are filling the 800 placed annually available, but just barely; practically speaking, there is no student selection.

"We are rapidly approaching the crisis situation which existed in 1954 when, of the 600 dental places in England and Wales, only 495 were taken up. This failure in recruitment led to the appointment of the McNair Committee in 1955 'to ascertain the reasons for the lack of candidates of suitable caliber for training as dentists and to indicate possible directions in which remedies might be sought.'

"Two causes of particular significance for the shortage of recruits to the dental profession were ascertained. The first was the public ignorance of the importance of dental health, and the second was the attitude of dentists toward their conditions of practice.

"They recommended that — to resolve the first difficulty — a comprehensive national program of dental health education was essential. To resolve the second difficulty, it was recommended that a thorough review of the whole system of remuneration in the General Dental Services should take place to correct the pattern of diminishing earnings in middle age and the general sense of financial insecurity.

"There is no reason to believe that these two causes of poor recruitment to dentistry are not as applicable today as they were 15 years ago. Nor is this surprising, because the comprehensive national campaign of dental health education never did materialize and practitioners still are suffering from a general sense of financial insecurity. "Indeed, in some areas of the country this aspect is now worse than it has been for years, and it is not wholly unconnected with the increase in dental charges imposed by the government last April.

"Since the inception of the National Health Service in 1948, not more than 30% of the population — at a generous estimate — has accepted regular dental treatment. This number is now likely to diminsh. (emphasis ours — Ed.)

"This would indicate that for 70% of the population it is not a question of dentistry and dentists having a good image or a poor image; there is no image at all. Is it any wonder that we have difficulty in attracting recruits when more than two thirds of the people are virtually unaware of our existence?"

"Now is the time to institute the comprehensive national program of dental health education. Now is the time to alert people to the importance of dental health, to the dental health benefits which they may claim to help them in financial difficulties."

And finally, a lengthy barrage of complaints from the practitioners, virtually all of an administrative nature.

JADA August 1972, General Dental Practices "Representatives of approximately 100 committees attended the 21st annual conference of local dental committees last April.

"The conference passed many resolutions, including those urging more realistic seniority payments; deploring the government's intent to reduce the exemption age limit for NHS charges; calling for further prior approval relaxations; advising local dental committies not to negotiate with individual executive councils on health center remuneration; pressing for improved terms of service in health centers and for dental remuneration in health centers to be the subject of review body recommendations; blaming government policies for the increasing practice of selective refusal of general dental services; requesting that more information be published on discretionary fees, and demanding the right to withdraw from contract if the dental estimates board assessment of discretionary items is unacceptable; seeking the legal right to use the title of

"doctor"; calling for grants and improved expense allowances for attendance as postgraduate courses; and pressing for a revised loose-leaf version of the **Dental Practitioner** handbook.

By reading these British reports in some continuity it should be apparent to each of us that our delivery system of dental services and all the freedom for progress in the conquest of the population's dental disease is pretty darned superior. Do we really want another "sad and complicated idiocy?" Our British colleagues are telling us something, if we but have the sense to listen.

Dr. James A. Nelson (left) of Haines, Alaska, was one of the dentists from the four corners of the United States who attended the Seminar on Pedodontics presented by the American Society of Dentistry for Children July 23-27 in the ADA Building, Chicago. Looking at the ASDC coloring book, "Hector & Timmy Tooth" with Dr. Nelson during a coffee break at the Seminar are (left to right) Dr. John Fujioka of Honolulu, Hawaii, Dr. R. W. Bacon of Eustis, Florida, and Dr. Alan W. Leathers of Cape Elizabeth, Maine. One general practitioner from each of the 52 ASDC State Units was invited to the four-day Seminar, expenses paid, through a grant from the Proctor & Gamble Co.

DR. FRIENCH SIMPSON, U.S. PUBLIC HEALTH SERVICE, DESCRIBES HIS ADVENTURES ABOARD THE USRC COMMODORE PERRY, IN ALASKAN WATERS, 1909

Edited by Ted C. Hinckley

Professor of History, San Jose State College

The following letter was written by a youthful physician enjoying a summer lark. As the document reveals, the 1909 voyage by Dr. Friench Simpson turned into a matter of life or death. Dr. Simpson's skill, and very probably the careful application of what he had recently read in a medical journal, enabled him to perform a successful appendectomy.[1]

Dr. Simpson obtained his M.D. from the University of Texas in 1903. He entered active service with the United States Public Health Service on October 6, 1906. According to his son, Dr. Friench Simpson, Jr., Professor of English at San Jose State College, the doctor's 1909 summer tour with the United States Revenue Marine (today's Coast Guard) was "the great adventure of my father's life, one that he never grew tired of talking about."[2] *Dr. Simpson was one of a number of junior officers in the Public Health Service that over the years, enjoyed mid-year tours with the Revenue Marine. By 1909 the annual Bering Sea Patrol had become almost legendary.*[3] *The billet was a fairly competitive one, and Physician Simpson obviously embarked upon it with real alacrity.*

Simpson's letter, as well as his scrapbook photograph, convey some of the enthusiastic escapism of his memorable cruise. Walter Lord has labeled the 1900-1910 decade "the Good Years." Theodore Roosevelt's exhortation to lead the "strenuous life," not to mention the robust writings of men like Jack London and Richard Harding Davis, challenged every virile young man. The fledgling U.S.P.H.S. doctor grabbed his chance "to see the world." Regrettably the ethnocentricism of the Anglo-Saxon, for which that age is equally notorious, also peeks out in Simpson's letter.

The Doctor's summer home and medical charge was the Commodore Perry, *a handsome cutter with a length of 165 and a 25-foot beam. Built in 1884, the trim* Perry *came to an ignominious end. One year after Simpson's cruise, she was lost on Tonki Point, St. Paul Island.*[4] *Doubtless the youthful physician was relieved when he heard that no hands had been lost.*

While Simpson's 1909 tour with the Bering Sea Patrol may have been the apogee of his professional adventures, his subsequent career was not dull. Among the doctor's other notable duty stations with the United States Public Health Service were plague eradication work at San Francisco, Fresno, and New Orleans, 1910-1914, and as Medical Officer attached to the U. S. Consulate General, Oslo, Norway, 1929-1930, Dublin, Ireland, 1930-1932, and Naples, Italy, 1932-1933. Dr. Simpson was on continuous duty from 1906 until November 1, 1941, when he reached the mandatory retirement age. He died on August 21, 1950.[5]

Dear Dr. Smith:

Your letter of July 7th, reached me Aug. 13th, which is pretty good Alaskan time, and though delayed was not less appreciated. It is a pleasure always to hear from the Fort, especially so when the letter comes from the Smith's, and this one was particularly enjoyed. So much so, I'm going to try to break my record and write you two letters in one year, unless of course you date Time from the end of the Service fiscal year and claim this the beginning of another! In that event I wil try at some future time to write you a third! If this severe test of friendship is passed, then I too hope we may see Service together again, 'and fight the Stanton battles over again'.

At the present writing we are lying 'tied up' at the wharf in Valdez,[6] awaiting for Court to convene, when some action will be taken in regard to the captured Japanese poachers, in which we are to appear as witnesses. It is understood that these Japs can be held only on a minor charge, and that the case will be quickly settled, but the usual Law's delay has set the trial for the 12th. of this month, and we must, perforce, await the time with patience.[7] This is our second visit to Valdez; there is no cable communication between this place and Unalaska, and lacking definite knowledge of the time of the Court's proposed session, we brought the prisoners down about the 1st. of September and had to return again to Unalaska.[8]

It is a far cry from this to my last letter to you, but I will go back 'a ways' and write about some of the things that have proved of interest to me. To take things up in their chronological order and not go back too far, and to get rid of "shop talk" at once, I will first tell you of the one serious case I have had, so far, on this cruise. About the middle of July a fireman reported at sick-call complaining of rather indefinite pain which lasted for two days and was never severe. The man remained on duty the first day, but at the end of

the second, at 6 p.m. while lying in his hammock, became suddenly very ill with all the symptoms of Acute Appendicitis. The Perry possesses nothing even resembling a Sick-bay, and full steam ahead was ordered for Unalaska. We had just completed our cruise to the Seal Islands and had begun our return journey. At 3 a.m. the patient began to develop symptoms of G.P., and I asked that the course be changed to pick up the "Bear".[9] We found her about 10 a.m., and Dr. Fox saw the case in consultation. The man's condition had improved somewhat, and we decided that the trip to Unalaska be continued, where operation could be performed conveniently. We again got under way at full speed, but at 3 p.m. the patient's condition became immediately dangerous, and picking up the "Rush" near St. George Island, I had Dr. Lanza in consultation, and we decided on immediate operation.[10] We anchored in the lee of the Island, and I got things ready. Used the 'galley' for the preparation of Instruments, etc., and converted the Cabin into a temporary operating-room, using the dining-table. At 4 p.m., with Dr. Lanza's assistance, operation was performed, and the diagnosis of G.P. verified. With extraordinary rapidity infection had extended everywhere, resulting undoubtedly from a rupture of the appendix. The usual methods of complete flushing and drainage were carried out. The anaesthetic was given by Lt. MagLaghlin, 2nd. Engineer, very successfully. The shock following was extreme, an uncountable pulse with sub-normal temp., and we did'nt expect the man to pull through the night, but he rallied towards morning, and the course to Unalaska was continued at full speed. In 36 hours we arrived at that place, but the condition was again extremely grave, and placing the man ashore, I had Dr. Stimpson in consultation, who happened to be in on the "Manning" at the time, and we decided on further surgical measures - a Colostomy. The man was sinking rapidly, and through the previous wound I entered the colon, stitching it to the sides of the wound, and fixing in it a catheter by means of a purse-string suture. Quantities of Normal Salt solution were introduced, and the reaction was wonderful to see! In one hour the pulse dropped from 140 to 90! This method was adopted as advised in a recent issue of the "Journal", and I am certain it was life saving in this particular case. I was detailed ashore during the next cruise of the Perry, where I remained 15 days looking after this case, who with many 'up's and down's', with the subsequent development of an abdominal abscess, which was opened, passed on to a condition of strength enabling him to go down to Port Townsend on the Tahoma for treatment in

Hospital. I understand he has now practically recovered. I have given you some of the details of this case, not from any personal desire to brag, for I merely followed the advice of my many consultants; rather I wished to indicate the wonderfull results following the Colostomy, and the remarkable recovery from such a seroius condition.[11]

When the Perry returned to Unalaska I joined her and we were ordered to again return to the Pribilof Islands for a short cruise, before taking the Japs down to Valdez. On this cruise we encountered our first storm. According to Sea nomenclature, it blew a "whole gale", and for three days there was 'no joy in Mud-ville'. For some reason not a single person became sea-sick, but we rolled and pitched so much we obtained little sleep, and eating was as amusing as it was difficult. Dining in the ward-room was out of the question, we had to brace ourselves in the pantry, hold on with one hand and forage for food with the other!

On the second day a rather severe roll loosened a boiler-brace resulting in a steam leak, and to minimize the danger we 'hove too' and there remained for 39 hours, riding out the storm. Finally things quieted down sufficiently to permit going ahead again. There being no sun we had no opportunity for a shot for position, and when land was again picked up we found that we had drifted 100 miles out of our course, and lay way to westward off Umnak Island.[12]Eventually, betwwen a pitch and a roll, we limped back to Unalaska, and it was a pleasure indeed to sleep in a quiet bunk again and have a bottle of - I mean, have a cup or plate 'stay put'!

The steam leak was fully repaired in Unalaska, we coaled and watered, put the Jap prisoners on board and stood out for Valdez, distance 1000 miles. The trip was rather uneventful; at Seward we picked up some July mail and there I learned that the Ohio had gone down near Ketchikan[13] with all Mrs. Simpson's August mail, my July check, and your last letter!

Arriving at Valdez we discharged our cargo of Japs, and were welcomed by her Citizens. The cause for this soon became apparent to us; all the able bodied unemployed were called upon to do guard-duty, at 4.00 per day and 4.00 per night, at the rate of about one guard per Jap, and we brought down seventeen!

The second day after our arrival all the Officers from Fort Liscom,[14] across the Sound from Valdez, called on the Ward room and were most sociable. The following day we took the Launch and returned the call, meeting most of the

Ladies at the Post. Two nights later we were entertained by the K.O., spending a most pleasant evening at cards, all the Officers and Ladies being present. We will return their hospitality during our present stay, not having an opportunity while here before.

The life at the Post was for all the world like Stanton, only we have a much better Station. One lady had just arranged for a 'striker'; another just arrived was making curtains for her Quarters! The conversation, the hopes and fears arising from life in the Service werejust the same. I felt very much at home; by substituting Marine-Hospital for Army a stranger could not have told the difference. The hostess, Mrs. Stritsinger, a most charming little lady, understood I might go to Angel Island, at the end of the end of this cruise, and assured me that it was a most pleasant location; Lt. and Mrs. Grober assured me that I would find much pleasure on any foreign detail in the Philippines or Japan; Dr. Clark had occupied adjoining Quarters to Dr. Fox, in the Philippines and was very pleasant in many ways.[15] We thoroughly enjoyed it all; these are the first white womenwith whom we have come in contact since last May!

On our return trip to Unalaska we had one single opportunity for a Ptarmigan hunt and bagged about twenty birds whish proved most delicious eating. These birds are quite numerous on many of the islands to the westward and on the Peninsula and offer excellent sport. Just at present they are to be found in the Salmon-berry bushes covering the hill-sides. Dr. Fricks would find rare sport with the dogs. Four times we have steamed by Unimak Island where is to be had the very finest 'Barren land' Caribou hunting. The Season was open, and there are said to be 25,000. on this Island, and we were assured that a hunt of four or five hours would bring success, but the Captain found no opportunity to stop; he is'nt keen on hunting, no matter how rare the opportunity. He knows nothing of the rare delighta hunter experiences on firing rapidly but successively at a column of deer: the 'put'-'put' of Turkey will never awaken him from a noon-day siesta on the dizzy mountain-top!

We reached Unalaska again and shortly the Rush, Bear and Thetis came in and tied up near. We formed quite a merry crowd, and there was much visiting between Ward-rooms with invitations for dinners out; much telling of experiences, much Fleet gossip.[17] The Perry was coaled, officially detached from the Fleet and ordered to return to Valdez on the 21st. We are the first to leave for home, and promptly at noon on the 21st. of last month we got under way. As we moved off our forward great gun was fired and immediately our "homeward bound" pennant was 'broken out' and soon streaming 240 ft. behind us in the breeze! With colors dipping on every flag-staff and every one waving a last good-bye-with eight bells just gone,

"The Ship was cheered, the Harbor cleared;
Merrily did we drop,
Below the Kirk, below the Hill
Below the Light-house top."

The Bear signaled in the code "a pleasant trip to you", to which we answered 'X.O.R.'-thank you", our last word as we stood out to sea. There is something stirring about the breaking out of a 'homeward bound pennant' to be felt most fully only after a cruise of 5 months in Bering Sea!

Through Unimak Pass we left Bering Sea, and I trust for good. In spots, I've had 'a bully' time, and the trip has offered much of interest and been very instructive, but in no way did it offer sufficient compensation for this long separation from my wife.

Our return trip to Valdez was made without a stop, and though the weather was beautiful all the way and the scenery magnificent, it was without special event. Shortly after our arrival snow began to fall, the largest flakes I've ever seen, and by morning about 14 inches lay on the Perry's decks. The surrounding mountain peaks received a fresh coat some time ago. During our former visit to this place we made a most interesting trip in a motor-car out to the foot of the Valdez Glacier, about four miles back of the town, and over some of the roughest road imaginable. It was wonderful to see the ease with which the car — a White Steamer — negotiated the boulders and gulches on the way. This road was really over the ancient bed of the glacier, which now dead, is slowly receding. We climbed up its face for a distance sufficient for inspection of some of the crevasses in the blue ice. Such glaciers are very common, and one - the Columbia - is quite near Valdez, is alive and said to be the most beautiful in the World. We had a fair view of it coming in.

We are going to entertain the "Army people" tomorrow night. We will run over to the Post, tie up at their Wharf and have them aboard for cards, and probably play 'Hearts'. We have a most excellent Steward, a chinaman, and in baking bread, making a salad or brewing coffee simply can't be beaten. Probably Mrs. Smith will be interested to know that we will take advantage of this ability and serve as refreshment, hot rolls, chicken salad and coffee. As prizes we have provided three Attu Baskets, costing us in the Attu Islands, from $3.00 to $5.00, but in the market here or in Seattle these things cost from $15. to $30. This grass work is very beautiful, and the Attu tribe is presumed to make the finest specimens. The ward-room and Cabin will be thrown together and as the Committee on Decoration, I'm going to use about 300 small silk flags that Lt. Waesche picked up while on his recent cruise to the Orient.

I had letters yesterday from Mrs. Simpson who is quite well but about given up hope of ever seeing me again. She is threatening to send the whole Bureau to the North pole! She has enjoyed hearing from Mrs. Smith very much, and has written me some of the news of the Fort. We are most anxious to get settled down together again, and she does'nt seem to care very much where, just so we have Quarters. I am asking to day for 30 day's leave at the termination of this cruise at San Pedro, Calif., but do not know what action will be taken. Feel sure I would be detached from the Perry in any event, and might be ordered away on reaching Seattle.

I wish you would say to Mr. Strachan that I was unable to pick up any Polar Bear skins at Unalaska; the schooners bringing them down are not yet due, and the Officers on the Thetis obtained only what they needed.[19] I wish to be remembered paricularly to him and to Mr. O'Bannon, and hope they are both doing fine. I suppose that O'Bannon's letter suffered the fate of most things coming up here - went down on the Ohio!

Ruby wrote me that Dorothy had a birth-day recently, and I should certainly like to see the little lady and Her Mother.

With kindest regards for Mrs. Bagg, the Mathewson's, Fricks' and all my friends on the Station,

I am sincerely yours,

Friench Simpson

CITATION

1. This document is in the possession of his son, Professor Friench Simpson, Jr., English Department, San Jose State College, San Jose, California.

2. Interview with Professor Simpson, San Jose State College, May 3, 1971. Actually the United States Public Health Service was until 1912 officially called the United States Public Health and Marine Hospital Service. L. F. Schmeckebier, *The Public Health Service: Its History, Activities and Organization* (Baltimore, 1923), 37.

3. A useful summary of the Coast Guard's role in Alaska is Byron L. Reed's "The Contribution of the Coast Guard to the Development of Alaska," *U. S. Naval Institute Proceedings*, LV (May, 1929), 406 ff. To appreciate something of how contemporaries of Dr. Simpson viewed it, read Joanna H. Nicholls Kyle's "Our Coast Police," *Overland Monthly*, XLII (November, 1903), 371-377.

4. U. S. Coast Guard, *Record of Movements Vessels of the United State Coast Guard 1790-December 31, 1933.* 2 Vols. (Washington, D.C., 1935), I, 258-263.

5. "Statement of Commissioned Service" from Department of Health, Education, and Welfare, Public Health Service, September 24, 1971.

6. The community of Valdez is located at the delta of the Valdez Glacier within a northeastern section of Alaska's Prince William Sound. This Sound is on Alaska's south-central coast facing the Gulf of Alaska. Originally called Copper City, Valdez had been expanded in 1898 as a port of entry on route to the Klondike. Donald J. Orth, *Dictionary of Alaska Place Names* (Washington, D.C., 1967), 1016. Hereafter this excellent source is cited simply, Orth, *Dictionary*.

7. Ecological balance between man and nature is not simply an anxiety of the automobile age. In the late-nineteenth century the puzzling problem of how to regulate the killing of the Pribilof Island's fur seals became a multi-nation dilemma. Pelagic hunters seeking seal pelts cared little for sovereign claims, while their quarry, the remarkable, open-sea-voyaging Pribilof fur seals, cared even less. National sovereignty was finally resolved in 1911, and the seals were saved from extinction. Julius W. Pratt, *A History of United States Foreign Policy* (New York, 1955), 355-359.

8. Unalaska Island was still an important commercial center for the Aleutian Islands. Orth, *Dictionary*, 1008.

9. The *Bear* was by any measure the most famous ship to ever serve in the U.S.R.M. or Coast Guard fleet. Many years later it was the *Bear* that transported Admiral Richard E. Byrd on his publicized voyages to Antarctica. Other U. S. Revenue Marine vessels that Simpson mentions in his letter besides the *Perry* and the *Bear* are the *Rush*, the *Manning*, and the *Thetis*. William Bixby's *Track of the Bear* (New York, 1965) is a well-told account of the remarkable *Bear*.

10. St. George Island was one of the two major Pribilof Islands. This isolated spot had its first Russian settlement about 1786. Orth, *Dictionary*, 826.

11. It is instructive to compare this appendectomy with one also carried out by Coast Guard personnel of the CGC *Winnebago* some years later. Paul R. Peak, Jr., "Appendectomy on Station Victor," *U. S. Coast Guard Academy Alumni Association Bulletin*, XXVII (September-October, 1965), 376 ff.

12. Umnak Island is part of the Fox Islands in the Aleutian chain. Orth, *Dictionary*, 1008.

13. Ketchikan is the first major Alaskan city that one reaches as he sails north from Seattle to Alaska's Panhandle. The *Ohio*, of the Alaska Steamship Company, was the largest vessel then regularly coming into Ketchikan. Robert De Armond, "This Month in Northland History," *Alaska Sportsman*, XXXIV (August, 1965), 22.

14. Let it be recalled that the United States had only recently acquired the Philippine Islands. As in the case of Puerto Rico and later Panama, this portion of the New Empire for some years challenged United States medical talent.

16. Just possibly the Captain had read some of the writings of John Muir or realized that modern technology increasingly tarnished the sportsmanship of hunting. See: Roderick Nash, *Wilderness and the American Mind* (New Haven, Conn., 1967), 150 ff.

17. This may seem like an excessive number of Revenue Marine vessels. However, aircraft and locomotives were then virtually unknown in Alaska. What else could carry the flag to the vast reaches of a land so enormous that it could easily swallow both Texas and California?

18. Dr. Simpson had been married but two and a half years when he signed on for his summer adventure aboard the *Perry*.

19. Once again we can note the sanguine if shallow belief then held by so many people that the resources of north America were limitless. An excellent examination of how ambiguous was the whiteman's view of the American Arcadia is Leo Marx's *The Machine in the Garden: Technology and the Pastoral Ideal in America* (London, 1964).

(Dr. Simpson's rather unorthodox spellings have been retained in the text. - Ed.)

NORTHERN HIGHLIGHTS - 3

Selected Abstracts on Medicine in the North

INH Toxicity

Brown, c. V., Acute isoniazid poisoning. *Amer. Review Resp. Dis. 105: 206-216, 1972.*

This study is a review of the pertinent American, British, and French medical literature on the toxic effects of isoniazid (INH) over-dosage. It also includes any analysis of the records of 42 Alaskan patients who suffered from isoniazid poisoning between 1956 and 1971. The author is Chief, Epidemiology Branch, Alaska Area Native Health Service.

The principal toxic effects of isoniazid are nausea, vomiting, blurred vision, increased visual sensitivity, dizziness, and slurred speech. These symptoms may progress to stupor and coma, grand mal or localized seizures, severe hypotension, cyanosis, and death. Six out of 31 American and British published cases were fatal, whereas none of the 26 cases from the French experience died although one patient remained decerebrate.

The author summarizes 42 cases occurring in Alaska Natives, with a detailed history on three of these. The patients ranged from 2½ and 47 years. The median age was 19 and the average age 21.6 years. The female to male ratio was approximately 3 to 1. Known amounts of INH ingested ranged from 0.5 gm to 30.0 gm. Nine patients died, at least three of them before treatment could be undertaken.

As a result of the experience gained from this series, Dr. Brown has developed a treatment regimen for isoniazid poisoning. In summary this consists of adequate air exchange, a forced diuresis, using Ringer's lactate with mannitol or furosemide, intravenous pyridoxine in the dosage of 1 gm for each gram of INH estimated to have been ingested, and sodium bicarbonate as needed to correct the metabolic acidosis. Diazepam may be used to control seizures.

Growth Patterns in Canadian Eskimos

Schaefer, O.: Pre- and post-natal growth acceleration and increased sugar consumption in Canadian Eskimos. *Can. Med. Assoc. J. 103: 1059-1068, 1970.*

This paper attempts to relate the recent growth characteristics of the Canadian Eskimos to the changing pattern of their dietary habits. Theauthor is with Northern Medical Research Unit of the Canadian Department of National Health and Welfare, in Edmonton, Alberta.

The author compares the per capita consumption of major nutrients by Eskimos from four sections of the Arctic, namely Hooman Island, Coppermine, Pangnirtung and Cumberland Sound, and Frobisher Bay.

The first three more traditional settlements demonstrated a high protein and relatively low fat and carbohydrate consumption, as compared with the more "urbanized" diet in Frobisher Bay. Over time there was in all areas a definite trend toward less protein consumption and more highly refined sugar intake.

Concomitant with these dietary changes was some evidence that birth weights were increasing and that the average heights, but not weights, of older children were greater than before. Comparable measurements of persons in the Cumberland Sound area taken in 1938 and again in 1968 and a highly significant increase in mean height was found. Mean weight, in fact, decreased although the change was not statistically significant.

It is hypothesized that these changes in phenotype are not due to genetic differences, since relatively little intermarriage has occurred in recent decades, but rather to nutritional changes, particularly the greatly increased consumption of rapidly absorbable carbohydrates, which the author feels is related to an excessive production of growth hormone. He compares this pattern of growth acceleration with that of the Icelanders, a genetically stable population with the same increase in sugar and decline in protein intake in recent decades.

Health Services in Northern Canada

Eber. D., Health care in the eastern arctic. *North 18: 24-29, March-April 1971.*

This article, prepared by a free-lance writer, describes some of the activities of the Northern Health Service in the Canadian Eastern Arctic. It is based on interviews with staff and consultants in Frobisher Bay, Cape Dorset, and Montreal.

The Northern Health Service operates a modern hospital at Frobisher Bay, and a number of isolated Nursing Stations on Baffin Island and elsewhere in the Franklin District. The hospital is the administrative headquarters for the service and is staffed by three doctors, a permanent staff member and a resident each from the Montreal General Hospital and the Montreal Children's Hospital. These two hospitals, both teaching centers for McGill University, also provide backup consultative services and are engaged in a number of related research activities. The nursing stations are generally staffed by two nurses, most of them trained abroad. They provide direct care, preventive services, and routine obstetrical care. As in Alaska, they are dependent on radio contact with the base hospital and periodic visits by the physicians.

The principal health problems encountered in the Eastern Arctic are respiratory disease, tuberculosis, which is now becoming less prevalent, chronic otitis media, mental illness, venereal disease, and a high birth rate. Programs are under way or being developed to cope with all of these. The costs of providing services are exceptionally high, however, with air charters as high as $1.80 per mile and a trailer nursing station costing $175,000.

Influenza at Klawock, Alaska

Clark, P.S., Feltz, E.T., List-Young, B., Ritter, D.G., Noble, G.R.: An influenza B epidemic within a remote Alaska community. Serologic, epidemiologic and clinical observations. *J.A.M.A. 214: 507-512, 1970.*

This paper describes the investigation of an influenza B epidemic at Klawock in January 1969. It was an unusual outbreak in that the majority of cases in the community were due to Type B virus even though Type A 2 was present both in Klawock and in other parts of Alaska at the same time. The authors were with the National Communicable Disease Center and with the Arctic Health Research Center.

Klawock is a Tlingit village located 80 miles from Ketchikan. The influenza epidemic began in late November 1968 and extended through early February 1969, reaching a peak in late January. A total of 150 persons out of a population of 181 gave a history of an influenza-like illness during this period. Influenza B virus was isolated from 5 out of 11 symptomatic persons from whom cultures were taken. A fourfold or greater rise in HI antibodies occurred in 26 persons and a single high titer of antibodies was recorded in 19 others. The presence of Type A 2 infection was also demonstrated but in a significantly fewer number of patients.

The overall attack rate was 83%, with the highest rates in school-age children (up to 96%). Males and females were equally susceptible. No significant reduction in illness could be demonstrated among those who had received influenza vaccine during the previous year. There were no hospitalizations but one death occurred, in a 40 year old man with a history of tuberculosis and emphysema.

The authors suggest that the virus was introduced into the community from the Seattle area, where it was known to be prevalent, during the Christmas holidays.

BOOK REVIEW

Federal Health Care (with Reservations!), by Robert L. Kane and Rosalie A. Kane. Springer Publishing Company, Inc., New York, 1972, 180 p $6.95.

This is an angry book by an angry young couple. It concerns the principal author's one year with the Indian Health Service in 1969-70 as Service Unit Director at the 75-bed PHS Indian Hospital in Shiprock, New Mexico, in the northeastern corner of the Navajo Reservation.

The authors describe their experiences and feelings with vividness and candor. They leave the reader in no doubt about how they view the way in which the Federal government has provided health care to the Indians. Yet they are forced to admit that in spite of all, the program has been successful in reducing infant mortality by 48% and tuberculosis deaths by 70%, to name only a few indicators, since 1955. And for all their criticism of the existing system, they recommend no fundamental change other than to eliminate the Area Offices, mainly to permit each tribe (or, apparently, each Service Unit Director) to vie with all the others by eloquence, politics, or persuasion, for a greater share of the Washington dollar. The effect of such a system on the smaller Indian tribes or communities, it might be added, would probably be disastrous.

It is difficult to review objectively a book in which the authors have made no pretense at objectivity. They have an axe to grind and they don't spare the Carborundum. Their perspective, however, is limited not only by their narrow experience in the IHS but by their lack of experience in any other health care system, including the private health care industry, which, incidentally, also comes in for its share of hard knocks. Dr. Kane came to the IHS directly out of a residency in Family and Community Medicine and, having fulfilled his draft obligation, he has since settled into a comfortable university slot, presumably for the duration. His wife is a social worker, who was not employed during their year at Shiprock.

In the Foreword, Dr. Howard J. Brown, a former teacher, states that the authors "typify the best of the new breed of young professionals." Such a breed, it would appear, needs a little domestication if it is to be effective as a change-agent, particularly in a cross-cultural setting. The many misconceptions, accusations, and innuendos in the book fairly cry out for rebuttal but such would be inappropriate in a brief review. Instead I will limit myself to a few specific points.

The Kanes give major emphasis to the alleged conflict between "careerists" and "two-year men;" the former as epitomes of tired reactionary incompetence set against the latter youthful purveyors of Vigor, Light, and Progress. The authors (need it be said?) consider themselves in the latter category, thwarted in their creativeness at every turn. The careerists are not all bad, merely inept, for the real villains are the higher levels of government, who manipulate the strings of power guided by exigencies of politics, hope of spoils, or equally dark motives.

Such a view degrades the Indian Health Service careerists, the majority of whom, incidentally, are Indians or Alaska Natives. They would be astonished to read their own descriptions as this book portrays them. The two-year men, meanwhile, are indeed the life-blood of the organization, but the inexperience and iconoclasm of some may not be considered an unmixed blessing by either the Indian consumers themselves or the Indian careerists.

In Chapter VII, the authors describe with immodest relish their own achievements at Shiprock. This is a catalogue of health activism, some of it good, some of it inappropriate, little of it new. What is most striking is the lack of meaningful involvement of the Navajo people in determining the policies and priorities of their health programs. Dr. Kane has no use for the Navajo Tribal Board of Health because it consists of elected officials whose motives are apparently, therefore, to be distrusted. An interesting concept of consumer involvement, indeed!

Beyond the bombast, this book has some strengths which should not be overlooked. The authors do point up a number of long-standing problems in the IHS which have rankled the staff for years - the problem of the medical versus non-medical administrator, the relative neglect of programs in accident prevention, the problem of inadequate funding for basic medical care, the insufficient use of paramedical workers, the tortuous planning and budgetary system, and the problems inherent in delivering health care to a widely scattered population. Their suggestions are often worth consideration within the Service.

But the publishers tout this book as offering "timely insight into factors that obstruct change in the delivery of health care" as the government debates a national health insurance plan. This is unreasonable, since the IHS, as even the Kanes admit, operates in an environment totally alien to that of the rest of the health care industry in this country. Cultural differences, competing religious and medical beliefs, logistical difficulties, staff recruitment problems due to the isolation of the facilities, and the awakening sense of identity and self-determination of the Indian people themselves make the IHS a unique program with its own set of challenges and solutions.

Lest the nits go unpicked, the publisher must share responsibility for the careless job of editing, proofreading, and production this book betrays. There are a number of misspellings in the text and the style seems to show a job hurriedly done. And, having spent a year at Fort Defiance and paid income taxes to Arizona, I was surprised to find in the index that it was in New Mexico.

The authors feel an obvious satisfaction in having unloaded their vexations, but many will wonder, including, I suspect, the Navajo people of Shiprock, whether their brief sojourn of activism was a positive or a negative force in the course of human events. - -Robert Fortuine, M.D.

Come Near, by Alexander H. Leighton. W. W. Norton & Co., Inc. New York, 1971. 351 p. $6.95.

This novel deserves brief notice here no less for its subject matter than for the unique background of its author. Dr. Leighton is a psychiatrist who is internationally known for his work on the epidemiology of mental disorders, particularly in New York City, Stirling County, Nova Scotia, and West Africa. Now the Chairman of the Department of Behavioral Sciences at the Harvard School of Public Health, he was formerly Chairman of the Department of Sociology and Anthropology at Cornell University in Ithaca, N. Y. Prior to and during this phase of his career, he did field work among the Navajos, the Nisei interned during World War II, and the Eskimos of St. Lawrence Island. He has published a great deal in these technical fields, but the present book is his first excursion into major creative writing.

The setting of this novel is Steller Island, somewhere in the Bering Sea, during late Territorial days. The story unfolds in the first person through the mind of Bill Williams, a young man who is weary of the sham, cruelty, sentimentality, and hopelessness of life in the early post war years. He attempts suicide by rowing out to sea from St. Michael but a storm brings him to Steller, where he is rescued by a party of Eskimos on a hunting trip. The book becomes then the story of his gradual return from cynicism and despair, largely due to his sometimes stormy relationships with the Eskimos, whom he comes to know intimately, and his evolving love for the public health nurse

who is a resident on the island. Jealousy, rage, warmth, fear, passion, love and hate are almost concurrent in the character of this complex intellectual who at first scorns all feeling but finally comes to understand it as the very basis of human existence. Williams, Peg the nurse, Ferguson the teacher, Hobart the sensitive Eskimo who dies of a massive pulmonary hemorrage, Randolph the vigorous rival-lover, Thomas the scholarly Eskimo at home in no one's world, and Sampson the shaman; - all of these and more are drawn with sensitivity and psychological insight, although one or two border on caricature. The people are trapped in a microcosm of life, death, and feeling, cut off from the world but very much a part of human existence.

Dr. Leighton's imagery is fresh and vigorous. His writing, however, is not for the casual bed-time reader. This book is ponderous at times and slow moving. It is full of literary allusions and the words and ideas betray the mind of the very well-read physician the author is. The plot is overly contrived, moreover, and the character of Williams rather implausible, especially since the reader learns nothing of the life which led up to his shoving off into the waters of Norton Sound. Except for some annoying misspellings, particularly of authors' names, my only other criticism is that some of the Eskimo-English dialect does not ring true to my ear. Eskimo culture, however, is portrayed with an insight and knowledge obviously based on personal acquaintance.

In sum, this book offers a unique but rather heavy experience in "extra-curricular" reading. I recommend it and hope that this man of many talents will continue his efforts in the literary genre. - - Robert Fortuine, M.D.

Current Concepts in Dyslexia, edited by Jack Harstein, price $12.00, published by C. V. Mosby, St. Louis, Missouri.

The purpose of this book is to provide the reader with an overall view of the terms, people and studies involved in the evaluation of children with a learning disability. Chapters are presented from the point of view of the opthalmoligist, educator, orthoptist, speech and hearing teacher and the neurologist. Drug therapy is also discussed.

At least five to twenty per cent of children have a learning disability (dyslexia), defined in this book as a condition in children with normal intelligence who have a learning disorder. Another definition presented is "a learning disability refers to a disorder or delayed development in one or more of the processes of speech, language, reading, spelling, writing or arithmetic, resulting from possible cerebral dysfunction and of emotional disturbance and NOT from mental retardation, sensory deprivation, or cultural or instructional factors".

Even more important than identification of the school-age child is the early identification of the pre-school disability learner. He is the child of 2½ to 3 years who has developed little or no language, has unintelligible speech, is physically immature, has poor co-ordination, is easily distracted and or exhibits hyperactivity or withdrawal symptoms. Early intervention is especially important as it may prevent the more complex and severe learning disability and there is less chance of emotional complications.

The book goes on to state that children with learning disabilities should have a battery of tests including tests of intellectual function, development diagnosis tests of achievement and tests of visual and auditory percept, motor co-ordination, visual-perceptual-motor integration, and verbal expression.

Normal children will have a straight-line test profile at average or above-average level. Retarded children straight-line profile at below average level. Dyslexia child's test pattern will show scatter within and or between subjects, and his profile abilities would be spiky, indicating strength in some areas and weakness in others.

Another point made is that a difference between lower verbal and higher performance IQ suggests that a depression of verbal language ability (one of the forms of dyslexia). In summary the author feels that the goals of the therapist should be to 1) set up a 90% "success situation" 2) improve child self-concept 3) help parent to teach child effectively how to manage environment to reduce overstrain, help child shift from one act to another without tears and to impose a schedule and a structure on child's daily activities.

The ultimate goal of the educator should not be the adjustment of child, but rather the rebuilding of the school program around the nature of the child (as it is illustrated by the interdisciplinary examination) and tailoring it to the assets of the child and bypassing his deficits when possible. The idea being that although ten to twenty percent of the white middle class population will still underachieve in reading after exhaustive diagnosis and treatment, these children do not have to be failures in life.

Betty W. Hunter, M.D.

BOOKS RECEIVED

1. *Textbook for The Orthopoedic Assistant* by F. Richard Schneider, price $10.75, published by C. V. Mosby and Co.

2. *Resistance to Trauma* by Zdenek Hruza M.D., published by Charles C. Thomas, Springfield, Illinois.

3. *Orthopoedic Surgery in Spasticity* by Harold M. Frost M.D., price $13.00, publisher, Charles C. Thomas, Springfield, Illinois.

4. *Prosthetic Replacement of the Aortic Valve* by Savage, Viggers, Berger, Robel, Sawyer, Wood. 217 pages, price $18.00, publisher Charles C. Thomas.

5. *A guide to Health Facilities - Personnel and Management* by Robert M. Sloane and Beverley Le Bov Sloane, price $5.95, publisher C. V. Mosby and Company.

6. *Clinical Pharmacology - Basic Principles in Therapeutics*, edited by Kenneth L. Melmon M.D., and Howard F. Morelli M.D., price $16.00, publisher, The MacMillan Company, 866 Third Ave., New York 10022, pages - 718.

7. *Review of Medical Microbiology*, 10th edition, 518 pages, by Ernest Jawetz PhD, Joseph L. Melnick PhD, and Edward A. Adelberg PhD., price $8.00, published by Lange Medical Publications, Los Altos, California.

8. *The American Language in the Kirillic Alphabet* by V. W. Shallacross, pages - 77, published by The Shorey Book Store, 815 Third Avenue, Seattle, Washington 98104.

9. *General Urology* by Donald R. Smith, M.D., pp 437, published by Lange Medical Publications, Los Altos, California, price $8.50.

10. *Review of Medical Pharmacology* by Frederick H. Meyers, Ernest Jowetz and Alan Goldfien, third edition, pp 687, published by Lange Medical Publications, Los Altos, California, price $8.50.

11. *Paramedical Pathology*, fundamentals of pathology for the Allied Medical Occupations, pp 200, published by Charles C. Thomas, 301-327 E. Lawrence Ave., Springfield, Illinois, price $12.50.

12. *Mental Retardation*, pp 430, illustrated, by Holmes, Moser, Holldorrsson, Mack, Pant and Matzilevich, published by The MacMillan Company, 866 Third Ave., New York 10022, price $28.00.

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